

State of Vermont

2005 - 2015

***Shaping the Future
of
Long Term Care
and
Independent Living***

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Table of Contents

Executive Summary	i
Methodology.....	1
The Changing Population.....	4
Disability Trends and Long Term Care Need.....	10
Shifting the Balance 2006	15
Nursing Facilities.....	18
Area Agencies on Aging.....	20
Best Practice Targets.....	22
Appendix	25

Executive Summary

The next fifteen years offer an opportunity to create a model long term care system for elders and adults with physical disabilities. With that in mind, the Vermont Department of Disabilities, Aging and Independent Living publishes its 4th edition of *Shaping the Future of Long Term Care & Independent Living 2005-2015*. This yearly report is intended to be a living document, adjusted annually to reflect changing demographics and trends. By using a rolling 10-year forecast of long term care need and use, the Department can continually plan and adjust for the future.

For over 30 years, the State of Vermont has had a policy of helping elders and adults with disabilities live with dignity and independence in the setting of their choice. Vermont's aging population and growing number of adults with physical disabilities will generate increased demands on the long term care system. Using a model developed by The Lewin Group that incorporates both demographic and program use data, the Department is able to project the need for long term care services and make recommendations for addressing that need.

Vermont's 1996 landmark legislation known as Act 160 has allowed the State to alter the balance between institutional and home and community-based services. The Act required the State to take saved dollars from reduced Medicaid nursing home utilization and shift those funds to home and community-based care. Prior to Act 160, Vermont spent 88% of its public long term care dollars on nursing facility care leaving 12% for home and community-based services. Today, the figures are 68% and 32% respectively, giving Vermonters greater choice in their long term care options.

Vermont is an aging state. Its elders age 65 and older are projected to more than double during the period 1990-2020. By 2020, older Vermonters will make up more than a fifth of the state's population. While Vermont ranked 26th in the nation for its proportion of elders in 2000, it is projected to rise to 8th highest in 2030. The state's fastest growing age group is its 65 to 74 year olds projected to grow 62% during the period 2005-2015. Those 85 years old and older are predicted to increase 26%, with growth for men at 42% and women at 19% resulting in a narrowed gender gap. Due to Vermont's lowest-in-the-nation birth rate, the state's youth (age 18 and younger) will decline by 9% between 2005 and 2015. Vermont's population as a whole is projected to grow 4% over the 10-year period.

Disability rates are a major determinate of the need for long term care. Although the prevalence of disability is rising for the younger population, it is decreasing for elders. Many of today's older Vermonters will live free of disability for longer periods of time. Nonetheless, Vermont will begin to witness the effects of the generational bulge in 2020. Demand for long term care services will not peak until after 2030, when the oldest "baby boomers" turn 85.

Declining disability and Vermont's aggressive efforts to improve and expand home and community-based services have led to a significant decrease in the use of nursing facility care. This decline is expected to continue throughout the 10-year period of this report generating increased demand for home and community-based services. The number of people with a disability living in the community (needing long term care services at the 2+ ADL level) is projected to grow by 36% over the next ten years. To address the expanding need, Vermont implemented a Long Term Care 1115 Medicaid Waiver in the Fall of 2005. This program, known as "Choices for Care," provides an entitlement to home and community-based services.

Choices for Care creates greater opportunities than in the past for expansion of the home and community-based system. To underscore this potential for expansion, the Department has included in this year's report a new section on "best practice targets" for the utilization of long term care services. Best practice targets were derived by blending the actual utilization of several high performing counties (high use of home and community-based services with lower use of nursing facilities) and then applying those targets across the state. Comparing actual use with best practice use allows counties to see the level of program utilization they might experience if they were to mirror a best practice standard. A handful of counties have met or exceeded the best practice targets in 2005.

Recommendations:

Progress has been made since the first issuance of recommendations in *Shaping the Future of Long Term Care 2000-2010*. Many of these recommendations remain "works in progress" as evidenced by the updates below.

These recommendations, if implemented, will result in a balanced and sustainable system of care for elders and adults with physical disabilities. Actual implementation in any given year will depend on the State's fiscal situation and assumes that Federal and State Medicaid revenues maintain historical trends. Vermont hopes to strike a more equal balance between the number of nursing facility residents and the number of people served in home and community-based settings through its Choices for Care 1115 Medicaid Waiver. If the goal of achieving a 60/40 balance were realized in each county (40 Medicaid home and community-based participants for every 60 Medicaid funded nursing facility residents), there would be sufficient savings to fund many of these recommendations.

The original recommendations from *Shaping the Future of Long Term Care 2000-2010* are in black type with the 2003 updates in red, the 2004 updates in blue, and the 2005 updates in green:

1. In accordance with consumer preference, continue to decrease reliance on nursing facility care. Develop alternatives so that at least 40% of the people

needing Medicaid funded nursing home level of care receive that care at home or in other community settings. Update this goal annually based on utilization and projected need. *Five of 12 counties have met or exceeded this goal in 2003. (Grand Isle and Essex are excluded because they lack nursing homes.) In 2004, no new counties have met this goal although Caledonia and Windsor are close. Caledonia and Windsor Counties have met the 60/40 balance bringing the state total to seven counties. Only five counties have not met the 60/40 ratio, one of which (Bennington) has only 15% of people receiving long term care in home and community-based settings.*

2. Increase Home and Community-Based Medicaid Waiver slots by 100 each year and continue to allocate them to people in greatest need. *Due to budget constraints, only 54 slots were allocated in FY 2003 but 100 will be allocated in FY 2004. Only 88 slots were allocated in FY 2004 and 73 are expected in FY 2005. There were 73 slots allocated in FY 2005. With the implementation of Vermont's Choices for Care 1115 Medicaid Waiver, slots no longer exist. Early results indicate an increase in the number of people served in the Choices for Care program.*
3. Increase the Attendant Services Program to serve an additional 100 people by 2010. *Growth was slower than expected, having risen from 250 clients in FY 2000 to 261 in FY 2003. To maintain the 2003 rate of use, while keeping pace with demographics, the program would have to serve 58 more clients per year by 2013 (i.e., 319 clients in 2013). The FY 2004 client count (260) is virtually unchanged from FY 2003. Additional funding in FY 2004 paid for an increase in participants' hours of care. The FY 2005 client count increased to 286. Although expenditures actually dropped 4% from FY 2004 to FY 2005, client turnover freed up funds to serve more people (newer clients required less intense services). If Attendant Services maintains its 2005 rate of use and keeps pace with demographics, it would serve 381 people in 2015.*
4. As funds permit, continue to improve wages and benefits for personal caregivers in all settings until caregivers receive a *starting* wage of at least \$10/hour, along with basic benefits such as health insurance, sick time and vacation leave. Wages in all settings should be increased annually by an inflation factor. *The only program with a starting wage of \$10/hour is the Consumer or Surrogate Directed Option in the Home and Community-Based Medicaid Waiver program. Progress has been made in both nursing facility wages and home health wages but more needs to be done. Due to budget constraints, there has been little progress on wages in FY 2004. Five of eleven Home Health Agencies have raised their starting wage to \$10/hour for personal caregivers and many Agencies provide benefits for caregivers working sufficient hours. The Department is working closely with the Community of Vermont Elders (COVE) on ways to improve recruitment and retention of direct care*

workers through COVE's Better Jobs Better Care grant and the Vermont Association of Professional Care Providers.

5. Develop additional supportive housing such as Enhanced Residential Care, Assisted Living, group-directed congregate housing, and adult family care. Increase funding for home modifications. Continue to promote universal design in all new housing construction. *Enhanced Residential Care and Assisted Living have expanded. Funding for home modification is increasingly inadequate. Promotion of universal building design is in progress. There are now 5 licensed Assisted Living Residences in Vermont, with more under development. As of March 2006, there were 6 Assisted Living Residences with 7 in the planning stages. Enhanced Residential Care grew 17% (155 to 182 residents) from FY 2004 to FY 2005 and is projected to serve 311 residents in 2015 at current use rates. The Vermont Center for Independent Living sponsored the state's second Universal Design Conference in April 2006 and is planning a future forum to showcase model home modifications and universal design.*
6. Increase the daily capacity of adult day centers from 441 in FY 2000 to 720 in FY 2010. *Daily capacity has grown to 565 in FY 2003. To maintain the 2003 rate of use, while keeping pace with demographic changes and the expected decline in nursing facility use, the program would have to serve 353 more clients by 2013 (i.e., 918 clients in 2013). Daily capacity reached 584 in FY 2004 with expected growth to reach 989 by 2014. Adult Day Services will likely expand as a result of inclusion in the 1115 Waiver. The number of Adult Day clients jumped to 836 in FY 2005, a 43% increase over FY 2004, far exceeding the 2009 projected daily capacity of 785. This gain occurred prior to implementation of Choices for Care and is due to expansions at several sites. If Adult Day Services maintain their 2005 rate of use and keep pace with demographics and the expected decline in nursing facility use, they would serve 1,287 people in 2015.*
7. Expand the capacity of the Area Agencies on Aging (AAA's) to provide case management to more elders who do not participate in the Medicaid Waiver program. Develop a program to provide case management assistance to adults with physical disabilities between the ages of 18 and 60 who do not qualify for such assistance from any other program. *No progress to date. The Area Agencies on Aging will likely receive substantial new State funding for FY 2006 to help stabilize rather than expand their operations. No additional funding has been identified to develop a case management system for younger adults with physical disabilities. For FY 2006, the AAA's received stabilization funding as well as one-time Global Commitment funding to assist in implementation of the Medicare Modernization Act Part D prescription drug plan. The absence of case management services for people 18-60 has become increasingly problematic and will likely attract more attention in 2006.*

8. Expand community-based health promotion and disease prevention programs for elders and adults with physical disabilities. *Expansions include strength training classes predominantly led by elders, the Senior Farmers' Market Nutrition Program, and a quarterly food and nutrition newsletter for providers. Governor Douglas established the Commission on Healthy Aging in 2005. A \$48,000 National Governors' Association grant will pay for staffing the Commission this year and procuring additional grants for future work. No additional grants were found. The Department now supports staffing the Commission whose focus this year is developing a Healthy Aging Plan in addition to other statewide initiatives. In FY 2006, Congressional earmark funds targeted to local senior centers will help implement changes to make their services more attractive to "baby boomers". The Commodities Supplemental Food Program experienced federal cuts that have resulted in fewer seniors being served.*
9. Expand the Homemaker Program to serve 1,300 people by the year 2010. In 2000, this program served 700 people. *Due to budget constraints and increased costs per client, the Homemaker Program served 614 people in FY 2003, 86 fewer than in FY 2000. To maintain the 2003 rate of use, while keeping pace with demographics, the program would have to serve 404 more clients per year by 2013 (i.e., 1,018 clients in 2013). The 2004 client count (612) is virtually unchanged from 2003 due to level funding. Homemaker Services will likely expand as a result of inclusion in the 1115 Waiver. The Homemaker Program served 648 people in FY 2005, a 6% increase over FY 2004 with no growth in Department funding; however, the Home Health Agencies contributed additional funds of their own. The increase in the number served occurred prior to implementation of Choices for Care and is probably the result of the additional Home Health Agency funds as well as client turnover which freed up funds to serve more people. If the program maintains its 2005 rate of use and keeps pace with demographics, it would serve 998 people in 2015. However, the trend from 2000 to 2005 shows a decline in the number served.*
10. Expand and improve the dissemination of public information so that all elders and adults with physical disabilities know how to access the services they need through web sites, publications, the media, and information and assistance lines. *The Senior Help-Guide has been widely distributed, the Guide to Services has been updated on the Department's web page, and radio and TV Public Service Announcements have been created. Funding has been found for a public information initiative in 2004. A public education media campaign has been initiated to publicize the Senior HelpLine and the Vermont Center for Independent Living (VCIL) information and referral line—the "I-Line". Additional funding in FY 2005 allowed for continuation of the public information campaign to promote the Senior HelpLine on a limited basis.*

11. New in 2003: *Obtain permission from the Centers for Medicare and Medicaid Services to implement an 1115 Long Term Care Medicaid Waiver to create equal access to either nursing facility or home and community-based care, according to the consumer's preference. As of this printing, the Department expects to receive final approval for the 1115 Medicaid Waiver with an implementation date of September 2005. Vermont began implementation of its Choices for Care 1115 Medicaid Waiver in October 2005, showcasing a remarkably smooth transition.*
12. New in 2005: *The Vermont Department of Disabilities, Aging and Independent Living (DAIL) received a \$2.1 million Real Choice Systems Change grant—Comprehensive System Reform (Health and Long Term Care Integration Project) from CMS to develop a system that integrates acute, primary and long term care for elders and people with disabilities. This includes capitating Medicare and Medicaid funds into a flexible pool to create a system of services more person-centered and responsive to individual needs.*
13. New in 2005: *DAIL received a Real Choice Systems Change grant—Quality Assurance and Quality Improvement to develop a comprehensive quality management system across the Department's home and community-based Medicaid waivers for elders, people with physical disabilities, traumatic brain injury survivors and people with developmental disabilities.*
14. New in 2005: *DAIL received a Real Choice Systems Change grant—Integrating Long Term Supports with Affordable and Accessible Housing to enhance housing capacity and supportive services so that Medicaid-eligible frail elders and adults with physical disabilities can live in the setting of their choice.*
15. New in 2005: *DAIL received a Robert Wood Johnson grant to implement a "Cash and Counseling" option for clients in the Choices for Care program.*

Methodology

The Vermont Department of Disabilities, Aging and Independent Living contracted with The Lewin Group to project both the need for long term care services and the capacity of Vermont's system to meet that need. The target populations are elders and adults with physical disabilities. Vermont-specific data on population growth, demographics, and program utilization were incorporated into the Lewin model to derive both "need" and "use" projections for 2010 and 2015.

Vermont population data from the U.S. Census 2000 served as the baseline. The University of Massachusetts Institute for Social and Economic Research (MISER) developed population projections for the period 2000 to 2020. The Lewin Group integrated the population projections with a variety of data sources, including disability data, population characteristics, nursing facility utilization, and the Department's Fiscal Year (FY) 2005 actual program use, to produce a set of tables that describes Vermont's need and use of long term care services by county.¹ (See Appendix, p.25.) Detailed methodology reports from both MISER and The Lewin Group are available upon request.

Two essential state-level assumptions drive the projections in this model: the disability rate trend and the nursing facility use rate trend. The first is a major determinate of long term care need, and the second influences the demand for services in the community. These assumptions can be adjusted over time as expected trends change. (See Appendix, Assumptions Sheet, p.26.)

The disability rate trend for individuals younger than 65 years old utilizes growth projections from the Social Security Administration to determine the increase in the percentage of workers receiving Disability Insurance benefits. This trend was applied to children as well because The Lewin Group lacked better data on which to base childhood trends. For people age 65 and older, the disability trend was derived from Manton's analysis of the 1999 National Long Term Care Survey.² This analysis showed a 1% decline per year (between 1989 and 1999) in the age-adjusted rate of disability. The Lewin model assumed a slightly smaller and flattening decline for the projections because there is debate as to whether these declines will continue into the future.

¹ To produce detailed disability estimates by county, Lewin relied principally on the following sources of data, all from the U.S. Bureau of the Census: (1) for county-level general disability data, the 2000 Public Use Microdata Sample (PUMS); (2) for detailed data on Activities of Daily Living (ADLs), the 1996 Survey of Income and Program Participation (SIPP); and (3) for county-level income distribution data, published estimates from the 2000 Census. Because detailed ADL data do not exist at the state or county level, ADL information from the SIPP was statistically matched to the county-level Census disability data to produce ADL estimates for each county.

² Manton, Kenneth F, and Gu, XiLiang, Changes in the Prevalence of Chronic Disability in the United States Black and Nonblack Population above Age 65 from 1982 to 1999. *Proceedings of the National Academy of Sciences*, Vol. 98, No. 11, 2001. This paper defines disability as having difficulty with one or more activities of daily living (ADLs). Lewin applied these age-adjusted trends to the estimates of disability, which are defined as requiring assistance with two or more ADLs. Separate analysis of National Long Term Care Survey data performed by The Lewin Group indicates that these two measures of disability, while different, experienced similar trends from 1982 to 1999.

The nursing facility use rate trend assumptions are based on an analysis of Vermont's actual nursing home use during the period 1992-2005. These data include all payers, both public and private, and incorporate observed trends in nursing facility use through the second quarter of 2005. The trends show the annual percent change in the per capita nursing facility use rate by age group. The model assumes that the five-year and ten-year trends in nursing facility use (i.e., to 2010 and 2015) will resemble the long-term trends observed from 1992 to 2005.

The trending assumptions for nursing facility use and for disability rates each affect the model's projections of both the need for long term care and the use of home and community based services. A decline in the assumed rate of nursing facility use results in a larger proportion of people with disabilities living in the community. This in turn increases the expected use of home and community based services. At the same time, a decrease in the expected disability rate within an age group (as among those age 65 and older) results in fewer people of that age group with disabilities in the community, which in turn reduces the expected use of home and community-based services.

While the foregoing discussion has focused on the impact of broad, state-level assumptions on projected need for and use of long term care, it is important to understand that the county-level estimates and projections also make use of numerous county-specific sources of data. These include county disability data from the 2000 Census, age-specific county demographic data, and actual age-specific data on county utilization of nursing facilities and home and community based services.

"Disability" is defined as requiring the help of another person to perform two or more activities of daily living (such as dressing, bathing, transferring, toileting, eating). The model excludes people with developmental disabilities. Individuals with mental illness are considered to have a disability only if they have 2 or more ADL limitations. *The numbers in this model represent a "point in time" as opposed to an unduplicated yearly total.* Nursing facility utilization figures represent an average daily census, while use of most other services reflects the average number of users over a one-month period. All "user" data are for the State's fiscal year. As a general rule, county designations for "user" data represent the user's current residence.

The tables in the Appendix display the results of the model. Tables 2 and 3 (p.27-30) show the number of Vermonters with long term care needs, employing more detailed population characteristics. The "low-income" delineation refers to people whose income is below 175% of the Federal Poverty Level, roughly capturing the majority of Vermont's publicly funded long term care clients.

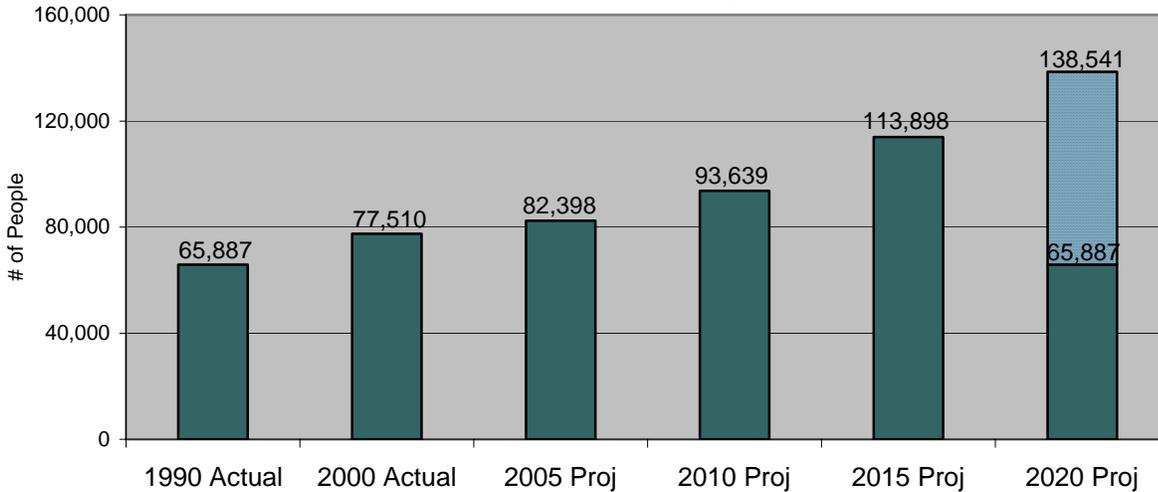
Tables 4 and 5 (p.31, 32) indicate the number of point-in-time "users" for each program or service; "users" in these tables may be served by more than one program. Statewide and county projected use for 2010 and 2015 is based on actual use in FY 2005, projected forward. Actual use in FY 2005 is *prior to* the implementation of Vermont's new Choices for Care Medicaid Waiver program. The projections of use for

2010 and 2015 assume that each county's *rate* of use of each service remains the same as in 2005 within each age group. Thus, use of home and community-based services in a county increases *only enough* to accommodate demographic changes in the county (e.g., aging and disability) and the expected shift from nursing facilities, assuming that historical trends in nursing facility use continue. These projections are meant to illustrate how expected changes in the community will affect use of home and community-based services in each county. For example, a county with relatively low rates of home and community-based service use in 2005 will still be projected to have low rates of use in 2015 relative to other counties.

The Changing Population

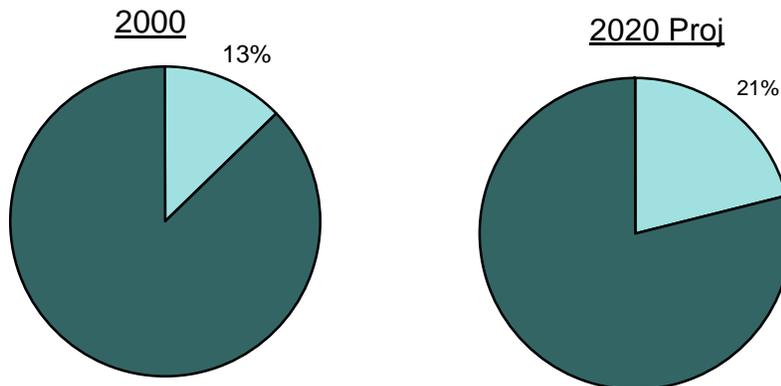
Vermont's older population—those 65 years old and older—is projected to more than double by 2020. Vermont's older citizens (65,887 in 1990) are predicted to number 138,541 by 2020. The doubling of elders can be seen in the chart below.

Population Growth for Vermonters
65 Years Old and Older
1990-2020 Projected*



Older Vermonters comprised 13% of the population in 2000, however, they are projected to make up more than one fifth of the populace in 2020, a mere 14 years from today. (See chart below).

Percent of Vermonters 65 years old and older
for 2000 and 2020 Projected*



* U.S. Census 2000 for "Actual", MISER for "Projected"

Vermont ranked 26th in the nation for its proportion of people age 65 and older in 2000. This ranking is predicted to change dramatically over the next 25 years, rising to 11th highest in 2010 and 8th highest in 2030. By 2030, Vermont's elderly are projected to account for 24.4% of the total population. (See table below.) Public policy needs to address the myriad of issues confronting Vermont should its elders comprise almost a quarter of the population.

Ranking of States by Projected Percent of Population Age 65 and Older: 2000, 2010 & 2030

U.S. Census Bureau, Population Division, Interim State Population Projections, 2005

2000 State	2000 Percent	2000 Rank	2010 State	2010 Percent	2010 Rank	2030 State	2030 Percent	2030 Rank
United States	12.4	(x)	United States	13.0	(x)	United States	19.7	(x)
Florida	17.6	1	Florida	17.8	1	Florida	27.1	1
Pennsylvania	15.6	2	West Virginia	16.0	2	Maine	26.5	2
West Virginia	15.3	3	Maine	15.6	3	Wyoming	26.5	3
Iowa	14.9	4	Pennsylvania	15.5	4	New Mexico	26.4	4
North Dakota	14.7	5	North Dakota	15.3	5	Montana	25.8	5
Rhode Island	14.5	6	Montana	15.0	6	North Dakota	25.1	6
Maine	14.4	7	Iowa	14.9	7	West Virginia	24.8	7
South Dakota	14.3	8	South Dakota	14.6	8	Vermont	24.4	8
Arkansas	14.0	9	Connecticut	14.4	9	Delaware	23.5	9
Connecticut	13.8	10	Arkansas	14.3	10	South Dakota	23.1	10
Nebraska	13.6	11	Vermont	14.3	11	Pennsylvania	22.6	11
Massachusetts	13.5	12	Hawaii	14.3	12	Iowa	22.4	12
Missouri	13.5	13	Delaware	14.1	13	Hawaii	22.3	13
Montana	13.4	14	Alabama	14.1	14	Arizona	22.1	14
Ohio	13.3	15	Rhode Island	14.1	15	South Carolina	22.0	15
Hawaii	13.3	16	New Mexico	14.1	16	Connecticut	21.5	16
Kansas	13.3	17	Wyoming	14.0	17	New Hampshire	21.4	17
New Jersey	13.2	18	Arizona	13.9	18	Rhode Island	21.4	18
Oklahoma	13.2	19	Missouri	13.9	19	Wisconsin	21.3	19
Wisconsin	13.1	20	Oklahoma	13.8	20	Alabama	21.3	20
Alabama	13.0	21	Nebraska	13.8	21	Massachusetts	20.9	21
Arizona	13.0	22	Ohio	13.7	22	Nebraska	20.6	22
Delaware	13.0	23	Massachusetts	13.7	23	Mississippi	20.5	23
New York	12.9	24	New Jersey	13.7	24	Ohio	20.4	24
Oregon	12.8	25	New York	13.6	25	Arkansas	20.3	25
Vermont	12.7	26	South Carolina	13.6	26	Missouri	20.2	26
Kentucky	12.5	27	Wisconsin	13.5	27	Kansas	20.2	27
Indiana	12.4	28	Kansas	13.4	28	New York	20.1	28
Tennessee	12.4	29	Tennessee	13.3	29	New Jersey	20.0	29
Michigan	12.3	30	Kentucky	13.1	30	Kentucky	19.8	30
Dist. of Columbia	12.2	31	Oregon	13.0	31	Louisiana	19.7	31
South Carolina	12.1	32	Michigan	12.8	32	Michigan	19.5	32
Minnesota	12.1	33	Mississippi	12.8	33	Oklahoma	19.4	33
Illinois	12.1	34	Indiana	12.7	34	Tennessee	19.2	34
Mississippi	12.1	35	Louisiana	12.6	35	Minnesota	18.9	35
North Carolina	12.0	36	New Hampshire	12.6	36	Virginia	18.8	36
New Hampshire	12.0	37	North Carolina	12.4	37	Nevada	18.6	37
Wyoming	11.7	38	Virginia	12.4	38	Idaho	18.3	38
New Mexico	11.7	39	Illinois	12.4	39	Oregon	18.2	39
Louisiana	11.6	40	Minnesota	12.4	40	Washington	18.1	40
Maryland	11.3	41	Nevada	12.3	41	Indiana	18.1	41
Idaho	11.3	42	Washington	12.2	42	Illinois	18.0	42
Washington	11.2	43	Maryland	12.2	43	California	17.8	43
Virginia	11.2	44	Idaho	12.0	44	North Carolina	17.8	44
Nevada	11.0	45	California	11.5	45	Maryland	17.6	45
California	10.6	46	Dist. of Columbia	11.5	46	Colorado	16.5	46
Texas	9.9	47	Colorado	10.7	47	Georgia	15.9	47
Colorado	9.7	48	Texas	10.5	48	Texas	15.6	48
Georgia	9.6	49	Georgia	10.2	49	Alaska	14.7	49
Utah	8.5	50	Utah	9.0	50	Dist. of Columbia	13.4	50
Alaska	5.7	51	Alaska	8.1	51	Utah	13.2	51

Population

Vermont's population is projected to surpass 650,000 by the year 2015. During the 10-year period 2005-2015, all the age groups will increase in size except for one. The number of children under 18 years old is projected to decrease by 13,000 due to Vermont's declining birth rate. Vermont has had the lowest birth rate in the nation for the last five years.³ The biggest increases will be seen in the 65-74 year old and the 85 year old and older age groups. The largest segment of the population is the 40-64 year olds comprising more than a third of the state's population. This group encompasses the "baby boom" generation. In 2005, the oldest "baby boomer" turned 59 years old while the youngest turned 41. The first "baby boomers" will turn 65 years old in 2011.

Vermont Population Growth*

Age	2000 Actual	2005 Projected	2010 Projected	2015 Projected
Under 18	147,523	140,909	131,292	127,914
18-39	180,529	174,511	175,936	178,960
40-64	203,265	228,117	238,374	231,427
65+	77,510	82,398	93,639	113,898
65-74	40,683	42,342	51,587	68,589
75-84	26,831	28,783	29,246	31,136
85+	9,996	11,272	12,807	14,173
Total	608,827	625,934	639,240	652,199

* Numbers may not total due to rounding.
U.S. Census 2000 for "Actual"
MISER for "Projected"

The Vermont population as a whole is projected to grow 4% during the 10-year period 2005-2015. The table on the following page depicts the percent change in the projected population growth for each age group during this period. Individuals under 18 years old are projected to decrease 7% during the first 5 years and then another 3%, ending the 10-year period with a 9% decrease. Although at low risk for needing long term care services, the fastest growing 65-74 year old group is projected to expand a dramatic 62%. Elders age 85 and older (85+) will grow 14% in the first period and an additional 11% in the second for a total of 26%. These "oldest old" are relatively small in number, however, they have the greatest need for long term care services.

³ National Vital Statistics Reports, Vol. 52, No. 19; Vol. 54, No. 2; & Vol. 54, No. 8. *National Center for Health Statistics.*

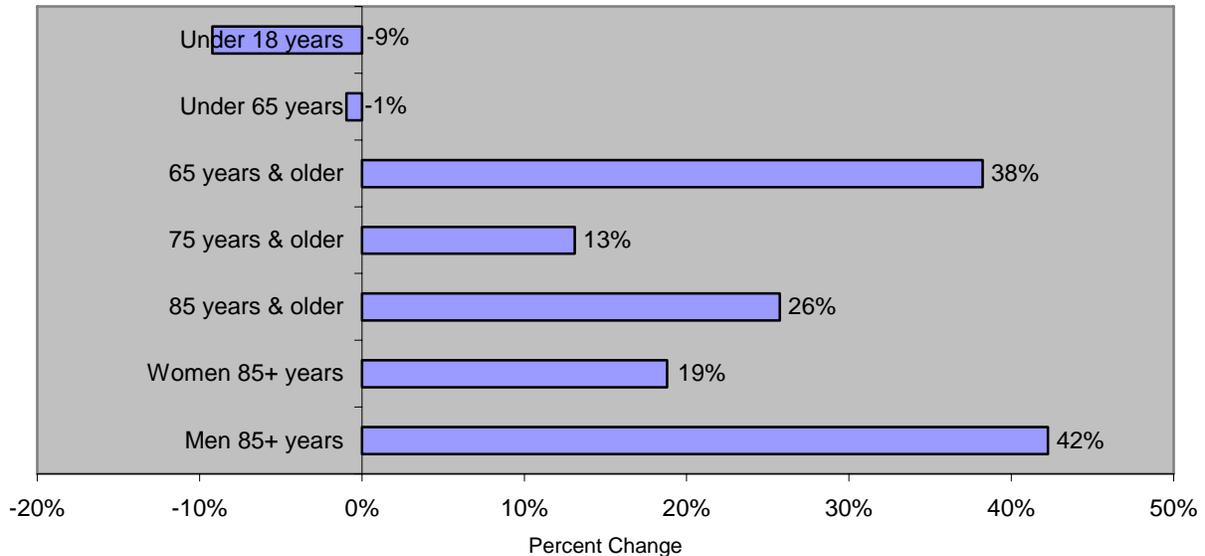
Percent Change in Population Growth*

Age	2005 to 2010 Projected	2010 to 2015 Projected	2005 to 2015 Projected
Under 18	-7%	-3%	-9%
18-39	1%	2%	3%
40-64	4%	-3%	1%
65+	14%	22%	38%
65-74	22%	33%	62%
75-84	2%	6%	8%
85+	14%	11%	26%
Total	2%	2%	4%

* Growth in first and second periods does not sum to growth over 10-year period because growth is compounded.

Older women far outnumber older men. In 2005, there were 47,041 Vermont women who were 65 years old and older compared with 35,358 men. This translates into a sex ratio of 133 women for every 100 men. Vermont's sex ratio increases with age as evidenced by those 85 years old and older. For this cohort, there were 240 women for every 100 men (70% female). However, Vermont's gender gap is projected to narrow due to the increase in life expectancy of older men. The table below shows the rapid growth among males age 85 and older, more than double that of women the same age. By 2015, the number of men 85 years and older is projected to increase by 42% (from 3,328 in 2005 to 4,734 in 2015) while the number of women will increase only 19% (from 7,945 in 2005 to 9,438 in 2015). The increasing proportion of men among older age groups will have ramifications for the long term care system, one of which is greater spousal support which will likely lead to decreased institutionalization.

Rate of Growth for Selected Age Groups 2005 to 2015 Projected



County Population—65+

The table on the right lists the projected number of individuals 65 years old and older in each county for 2005, 2010 and 2015. Chittenden County has the most elders with Rutland following. Although Washington County is the third most populous county in the state, Windsor has the third highest number of elders. Essex and Grand Isle have the lowest. A comparison of the time periods shows some counties growing faster than others.

65+ Population

	2005	2010 Proj	2015 Proj
Vermont	82,398	93,639	113,898
Addison	4,346	5,067	6,352
Bennington	6,448	7,067	8,121
Caledonia	4,421	4,811	5,815
Chittenden	15,000	17,452	21,850
Essex	1,042	1,192	1,370
Franklin	5,333	6,117	7,405
Grand Isle	1,036	1,323	1,707
Lamoille	2,967	3,547	4,495
Orange	3,918	4,506	5,570
Orleans	4,211	4,761	5,574
Rutland	9,782	10,821	12,729
Washington	7,801	8,708	10,772
Windham	6,578	7,588	9,419
Windsor	9,514	10,679	12,719

65+ Population--Percent Growth

	2005-2010 Proj	2010-2015 Proj	2005-2015 Proj
Vermont	14%	22%	38%
Addison	17%	25%	46%
Bennington	10%	15%	26%
Caledonia	9%	21%	32%
Chittenden	16%	25%	46%
Essex	14%	15%	31%
Franklin	15%	21%	39%
Grand Isle	28%	29%	65%
Lamoille	20%	27%	51%
Orange	15%	24%	42%
Orleans	13%	17%	32%
Rutland	11%	18%	30%
Washington	12%	24%	38%
Windham	15%	24%	43%
Windsor	12%	19%	34%

65+ Population—Percent Growth

Elderly Vermonters 65 years old and older are projected to grow 14% over the next five years and 22% in the following 5-year period. For the 10-year period (2005-2015), projected growth will be 38%. (See table on left.) Although Grand Isle is projected to have the steepest increases, these numbers are partly a reflection of its small size. Most of the counties reflect significant growth in this age group. Those counties projected to grow at a *slower* rate than the state average over the 10-year period are Bennington, Caledonia, Essex, Orleans, Rutland and Windsor.

County Population—85+ “Oldest Old”

Vermont’s “Oldest Old” play a significant role in the long term care system as these are the people most likely to utilize long term care services. The table on the right shows the projected number of individuals 85 years old and older for each county in 2005, 2010 and 2015. The most compelling aspect of these numbers is the rate of growth over the next ten years.

85+ Population

	2005	2010 Proj	2015 Proj
Vermont	11,272	12,807	14,173
Addison	566	659	737
Bennington	920	1,010	1,169
Caledonia	599	716	798
Chittenden	2,129	2,505	2,873
Essex	109	130	155
Franklin	617	728	833
Grand Isle	74	103	125
Lamoille	389	434	468
Orange	454	529	598
Orleans	616	690	746
Rutland	1,414	1,562	1,681
Washington	1,174	1,237	1,286
Windham	932	1,027	1,117
Windsor	1,282	1,475	1,588

85+ Population--Percent Growth

2005-2010 Proj 2010-2015 Proj **2005-2015 Proj**

	2005-2010 Proj	2010-2015 Proj	2005-2015 Proj
Vermont	14%	11%	26%
Addison	16%	12%	30%
Bennington	10%	16%	27%
Caledonia	20%	11%	33%
Chittenden	18%	15%	35%
Essex	20%	18%	42%
Franklin	18%	14%	35%
Grand Isle	40%	21%	69%
Lamoille	11%	8%	20%
Orange	16%	13%	32%
Orleans	12%	8%	21%
Rutland	10%	8%	19%
Washington	5%	4%	10%
Windham	10%	9%	20%
Windsor	15%	8%	24%

85+ Population—Percent Growth

The table on the left shows the percent growth for those 85 years old and older. The state is projected to grow 14% and 11% for the first two periods respectively, and 26% for the 10-year period 2005-2015. Those counties projected to grow *faster* than the state average over the next 10 years—Addison, Bennington, Caledonia, Chittenden, Essex, Franklin, Grand Isle, and Orange—need to be prepared for the increased demand in long term care services.

Disability Trends & Long Term Care Need

Disability Trends

Disability rates are a major determinate of the need for long term care. For individuals birth to 64 years old, the disability trend is on the rise. The Department's model predicts that the prevalence of disability will climb by 3.0% annually in the period 2005-2010 and another 2.6% annually in the second period 2010-2015. (See Trends table below.) Disability rates for this age group are expected to grow in part because of improved medical care that has allowed children with disabilities to survive birth and early childhood, and allowed adults with disabilities to live longer.

Today's older Vermonters are healthier than those in previous generations. More of them will live free of disability for longer periods of time. The Department's model predicts a decline in the disability rate of almost 1% annually for Vermonters age 65 and older during the period 2005-2010. This decline persists through the second period, slowing only slightly to -0.8%. (See Trends table below.) National findings support this decrease in the disability rate for people 65 years old and older.⁴ The decline is attributable to a number of factors: improvements in health, nutrition, and medical treatments; a shift away from manual labor; new medical technologies; lifestyle changes; and improved socioeconomic status, especially with regard to education. Studies have shown that educated individuals have a disability rate half that of less educated people.

Trends in Vermont Disability Rates:
 Projected *Annual % Change* in
 Per Capita Disability Rates

Age	2000-2005	2005-2010	2010-2015
Birth-64	3.7%	3.0%	2.6%
65+	-0.9%	-0.9%	-0.8%

The Department's model projects the number of people with a disability for 2005, 2010, and 2015. "Disability" is defined as requiring the help of another person to perform two or more activities of daily living. (See Appendix, Tables 2 & 3, p.27-30 for disability data.) The next table shows the estimated number of non-institutionalized Vermonters with a disability as well as the percent growth for each of the periods. (For county data, see Appendix, Table 3b, p.30.) In 2005, there were an estimated 4,406 Vermonters (18 years old and older) living in the community who required assistance with at least two activities of daily living. That number is projected to climb to 5,144 in 2010 and 5,994 in 2015 representing growth of 17% in each period. The

⁴ See Footnote #2.

growth in the number of 65+ disabled people over the 10-year period is twice that of the 18-64 year olds, 42% versus 21%. (Note that during this period, the total 65+ population is projected to grow by 40% compared to growth of only 2% for those 18-64 years old which in part explains the declining rate of disability among the elderly.)

Age	Number of Disabled*			Percent Growth		
	2005	2010 proj	2015 proj	2005-2010 proj	2010-2015 proj	2005-2015 proj
18-64	1,279	1,371	1,547	7%	13%	21%
65+	3,126	3,774	4,447	21%	18%	42%
Total	4,406	5,144	5,994	17%	17%	36%

* Numbers may not total due to rounding.

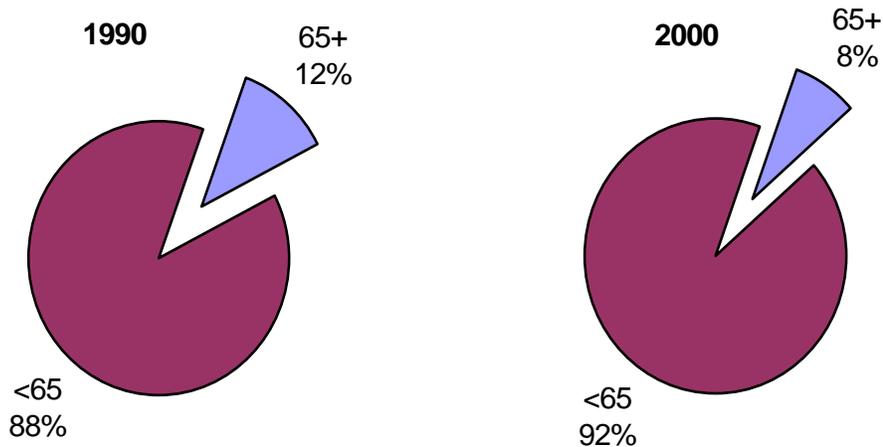
The number of non-institutionalized (community-dwelling) people with disabilities (2+ ADLs) per 1,000 non-institutionalized (community-dwelling) individuals is displayed in the table below. As expected, those 65 years and older have the highest rates. Orleans County has the highest rate of community-dwelling people with disabilities age 18 and older and the second highest rate for those 65 years old and older, both of which speak to the need for a robust home and community-based system in that county. This table allows counties to compare themselves with other counties as well as with the state average.

Number of Non-Institutionalized People w/ Disabilities per 1,000 Non-Institutionalized People—2005

	18+ Population	18-64 Population	65+ Population
Vermont	9.2	3.2	39.4
Addison	8.5	3.1	39.4
Bennington	10.5	3.2	38.1
Caledonia	10.0	3.3	39.5
Chittenden	7.7	3.2	40.2
Essex	10.1	3.4	35.5
Franklin	8.2	3.1	37.3
Grand Isle	8.1	3.1	30.8
Lamoille	8.3	3.2	36.6
Orange	9.5	3.1	39.6
Orleans	11.1	3.4	42.3
Rutland	10.4	3.3	40.9
Washington	8.9	3.1	39.1
Windham	10.4	3.2	43.0
Windsor	10.2	3.1	37.7

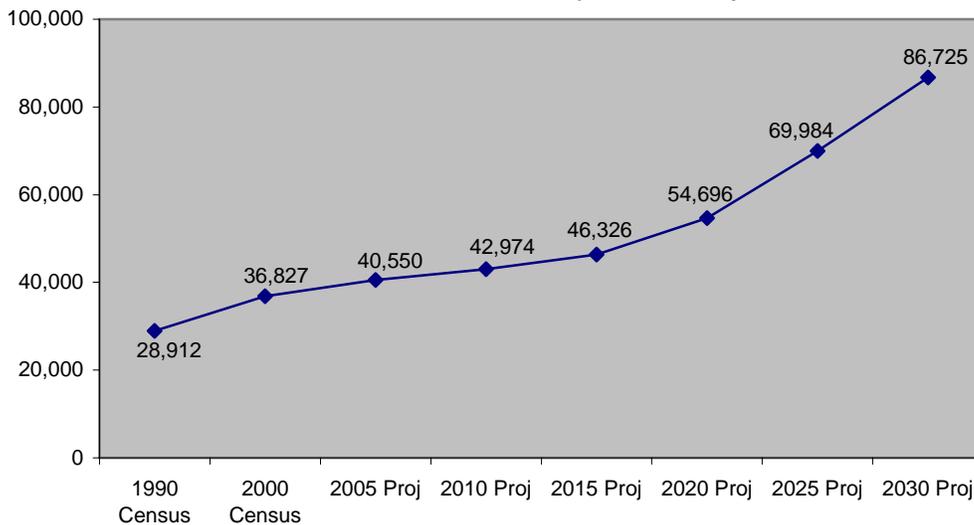
Education and income are factors in the declining rate of disability and often go hand in hand. Elderly Vermonters are more educated and more prosperous than in previous generations. The percent of Vermonters age 65 and older living in poverty has shrunk considerably, from 12% to 8%, in the ten years between 1990 and 2000.

Vermonters 65+ Living in Poverty



The “baby boom” wave created by people born between 1946 and 1964 will have a dramatic effect on the long term care system due to the growth in the number of elderly individuals. Assuming that many people need support and services by their mid-seventies, the oldest “baby boomers” (born in 1946) will begin to require services in 2020, just as the number of people 75 years old and older begins to climb. (See chart below.) Demand for long term care services will not peak until after 2030, when the oldest “baby boomers” turn 85.⁵

Vermont Population Growth--Age 75 and Older U.S. Census, Interim State Population Projections, 2005

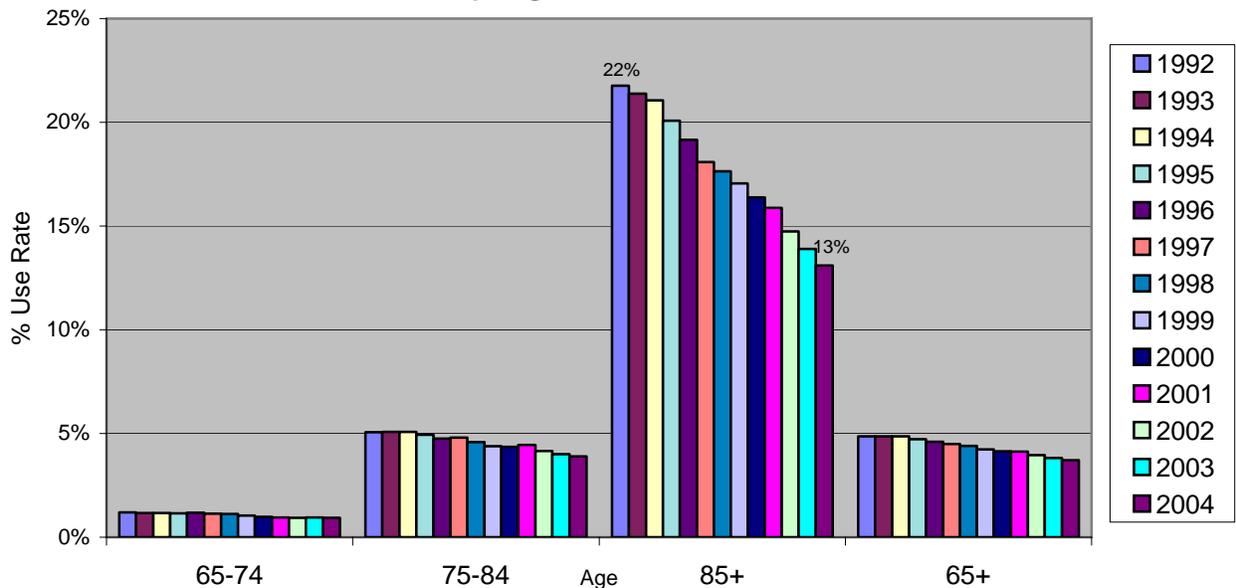


⁵ Redfoot, Donald L, and Pandya, Sheel M, Before the Boom: Trends in Long-Term Supportive Services for Older Americans With Disabilities. *AARP Public Policy Institute Issue Paper*, #2002-15 (October 2002).

Long Term Care Need

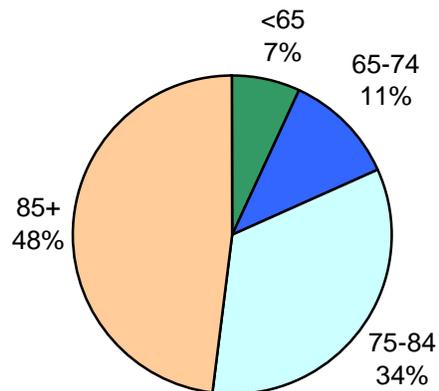
Declining disability and Vermont's aggressive efforts to improve and expand home and community-based services have led to a significant decrease in the use of nursing facility care. In 1996 when Act 160 became law, there were 3,600 people in nursing homes; as of December 2005, there were 3,150—a decrease of 450 residents. Vermonters age 85 and older have experienced an unusually dramatic decline in nursing home utilization. In 1992, approximately 22% percent of Vermont's 85+ year olds lived in nursing homes. For 2004, that number has dropped to 13%. (See chart below.)

Percent of Vermont Elders Residing in Nursing Homes
By Age 1992-2004



This striking reduction is particularly noteworthy given that people 85 years old and older comprise nearly half of Vermont's nursing home population. (See below.)

Age Mix of Nursing Home Residents--2005



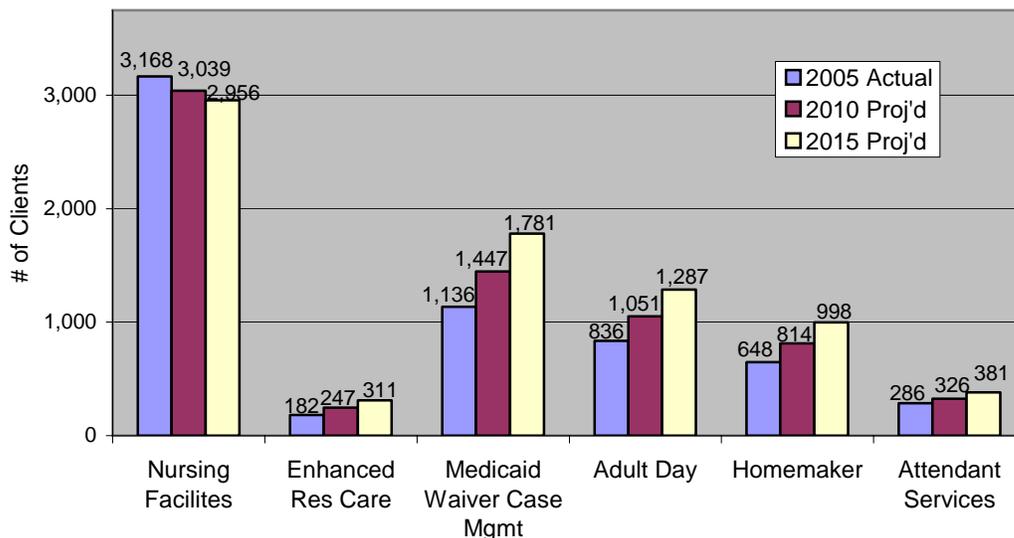
The overall decline in nursing facility use is expected to continue throughout the 10-year period in every age group. (See table below.) For those age 85 and older, the Department's model predicts a 3.5% annual decrease in per capita nursing home use during both periods. These trends are based on an analysis of Vermont's actual nursing home use from 1992 to 2005.

Trends in Vermont Nursing Home Use Rates:
 Projected *Annual % Change* in Per Capita
 Nursing Home Use Rates

Age	2005-2010	2010-2015
Birth-64	-0.2%	-0.2%
65-74	-2.4%	-2.4%
75-84	-1.8%	-1.8%
85+	-3.5%	-3.5%

Preference for home and community-based care coupled with the decline in nursing facility use has led to an increased demand for home and community-based services. (For projected growth rates, see Appendix, Table 4, p.31). The projected number of users for selected services is displayed below. These projections are based on actual program use counts in FY 2005, prior to the implementation of Choices for Care. This level of projected growth in the use of home-based services highlights the importance of shifting resources from institutional care to home and community-based options. Vermont's new Choices for Care program represents a major policy shift in this direction.

Use of Selected Services
 Actual and Projected Number Served*

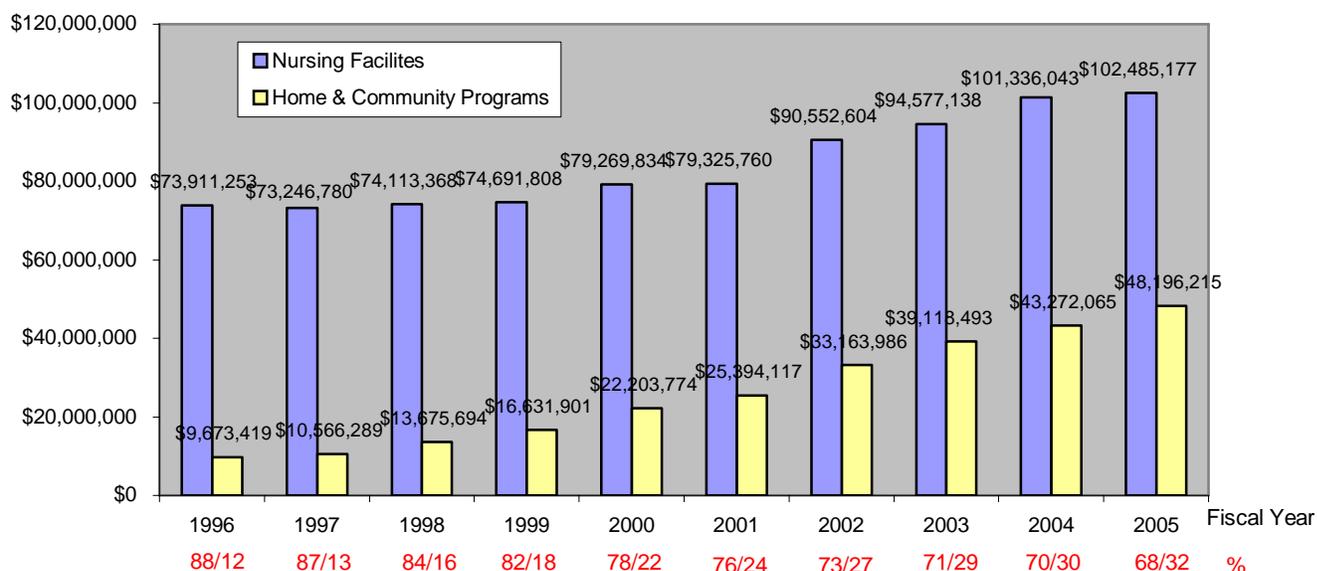


* Clients can be served by more than one program.

Shifting the Balance 2006

Vermont has made significant headway in transforming its long term care system to one that serves people in the setting of their choice. Only 12% of public long term care dollars went towards home and community-based care in FY 1996 while 88% was spent on nursing facility care. Roughly 10 years later (in FY 2005), 32% of long term care expenditures was dedicated to home and community-based care while 68% paid for institutional care. (See red numbers in chart below.)

Comparison of Public Expenditures for Nursing Facilities
and Home & Community-Based Programs
FY 1996--FY 2005



A New Entitlement for Home-Based Care

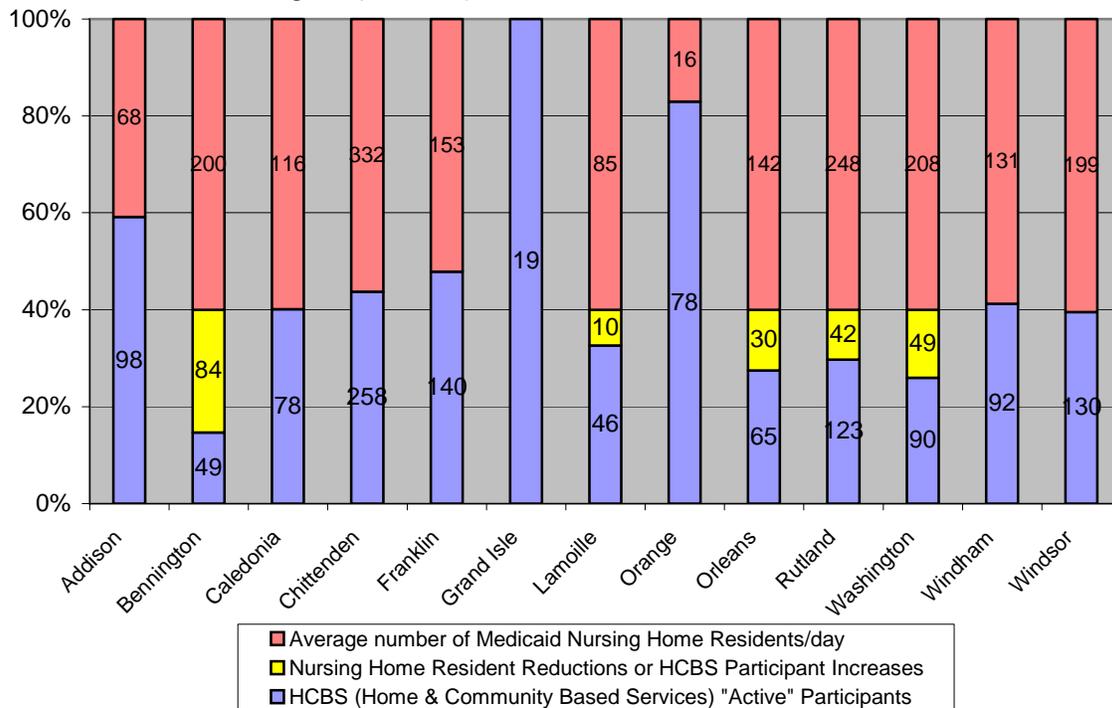
In late 2005, Vermont took its most dramatic step since the passage of Act 160 in reshaping its long term care system. The Department began implementation of a new 1115 Medicaid Waiver that allows Vermont to offer an entitlement to home and community-based services. The Department believes this will be a crucial step in truly “shifting the balance” of Vermont’s long term care system.

The Choices for Care program will allow Vermont to serve more people than it would have otherwise while managing the system within the available funds so as to avoid creating a “runaway” entitlement. Although the program is in its infancy, early results appear promising.

The concept behind this new Medicaid Waiver is that people should have equal access to either a nursing facility or home and community-based care. The key element is that consumers have multiple options and the right to choose services in their preferred setting, based on their assessed needs. The Department believes that, if given the choice, more consumers will choose home-based alternatives. Since that care is on average less costly than institutional care, Vermont should be able to serve more people for the same amount of money. This approach is a boon for the State budget as well as for consumers. Prior to the implementation of Choices for Care, people had to wait in line for home-based care while nursing facility care was an entitlement. (Vermont's previous 1915(c) Medicaid Waiver limited the number of "slots" for home-based care.) Choices for Care allows the Department to manage the long term care system within the available dollars, regardless of the setting.

Vermont hopes to create a balanced system such that for every 100 people receiving Medicaid Choices for Care services, no fewer than 40 are served by the home and community-based system and no more than 60 are served in nursing facilities. The 60/40 balance has been achieved in seven of Vermont's fourteen counties. The Department believes that once the 60/40 balance is attained statewide, Vermont can begin to plan for a more equal "50/50" balance. The following Choices for Care chart shows the number of nursing home residents in red and the number of home and community-based participants in blue, with yellow representing the increase in home and community-based clients (or decrease in nursing home residents) needed to realize the 60/40 balance.

Medicaid *Choices for Care*: Nursing Home Residents and Home & Community-Based Participants--March 2006
Changes (Yellow) Needed to Achieve 60/40 Balance



A key element of the Choices for Care (CFC) Waiver is the State's capacity to limit the funds it will spend. While Vermont has created an entitlement to both nursing facility and home and community-based care, it is only for people with the highest needs. A small percentage (estimated at 10%) of people who would otherwise be eligible for nursing home level of care may have to wait for CFC services if funds are not available. The Department is confident that the waiting list will be modest.

Vermont received its Waiver approval from the federal government after three years of planning and negotiations. Many states across the country are watching Vermont's experiment closely to see if it could assist in addressing their long term care budget problems while providing consumers with greater choice.

Effect on the System

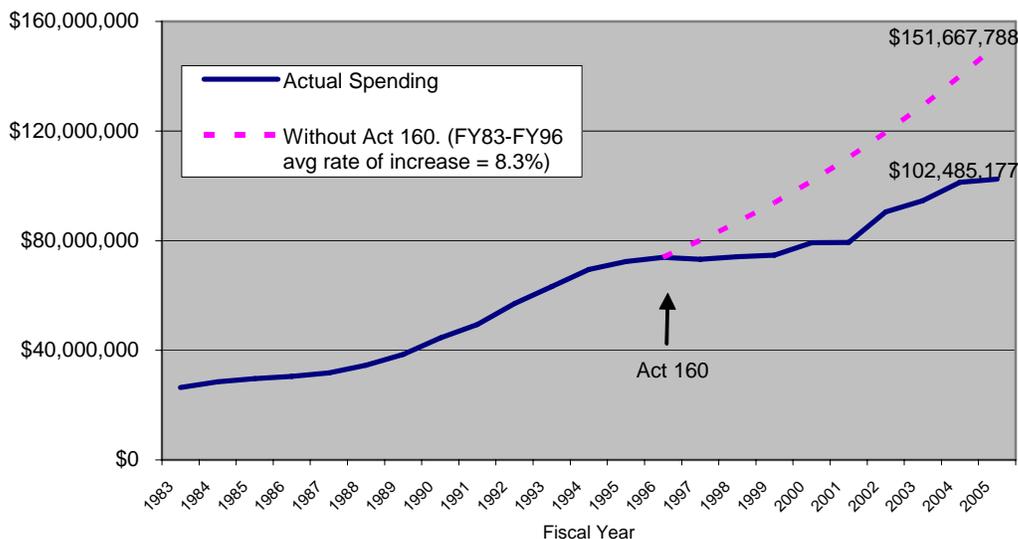
If use of home and community-based services increases as predicted, growth will occur in home health, adult day, and residential care services along with increased demands on the Area Agencies on Aging. All parts of the system are poised to expand.

- Many Adult Day Service providers have increased their capacity or are actively planning for expansion. In March 2006, the Department approved a new Adult Day program in Newport. Vermont now has 14 centers.
- A new home health agency was granted a Certificate of Need in 2005, the first in many years. Professional Nurses Service will be a statewide provider of Medicare and Medicaid services, including the new Choices for Care program. For the first time ever, home health agencies will be subject to State regulations beginning in 2006 as a result of legislation passed in 2005. The goals of the legislation include setting standards for access and quality of care.
- Assisted Living continues its slow but steady development with 6 licensed providers in the state and 7 in active planning.
- Residential Care Homes have received \$150,000 in one-time funding for improvements to help them serve more nursing home eligible people.
- The Department wants to take a close look at the possibility of developing "Green Houses" as an alternative to traditional nursing facilities. Based on the model developed by Dr. Bill Thomas, the Green House incorporates a total rethinking of the architecture, organization, staffing and philosophy of care normally associated with nursing facilities. This model encourages independence within a home atmosphere because it is organized around the needs of the resident rather than the needs of the institution.
- One of the most significant challenges remains the funding for community-based transportation. Changes in the management of Vermont's transportation program coupled with high fuel prices have severely challenged transportation providers. Without sufficient community transportation, elders and people with disabilities will not be able to access needed services.

Nursing Facilities

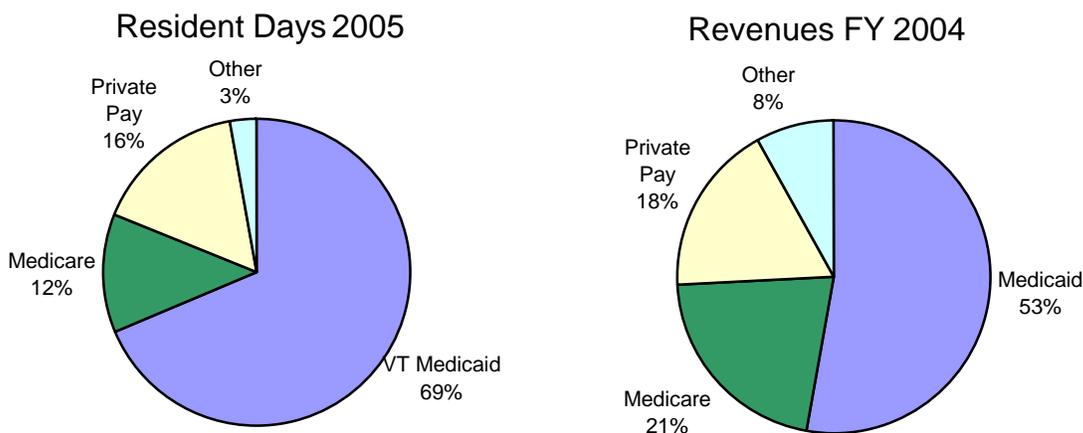
Since Act 160 began in 1996, Vermont has witnessed a net loss of 387 licensed nursing facility beds. Vacant beds throughout the state averaged 300 during 2005 with overall occupancy hovering around 91%. Nevertheless, Medicaid expenditures for nursing facilities have continued to rise. However, without Act 160, Medicaid expenditures would have been almost \$50 million greater. (See chart below.)

Nursing Home Medicaid Expenditures Actual vs "Without Act 160" *



Medicaid is the industry's dominant payer in both resident days and dollars. Total nursing facility resident days numbered 1.1 million with Medicaid days accounting for 69% of the total in 2005. (See pie chart on left.) Total revenues stood at \$213.5 million in FY 2004 (the latest data available) with Medicaid revenues comprising 53% of the total. (See pie chart on right.)

Nursing Facility Days and Dollars by Payer



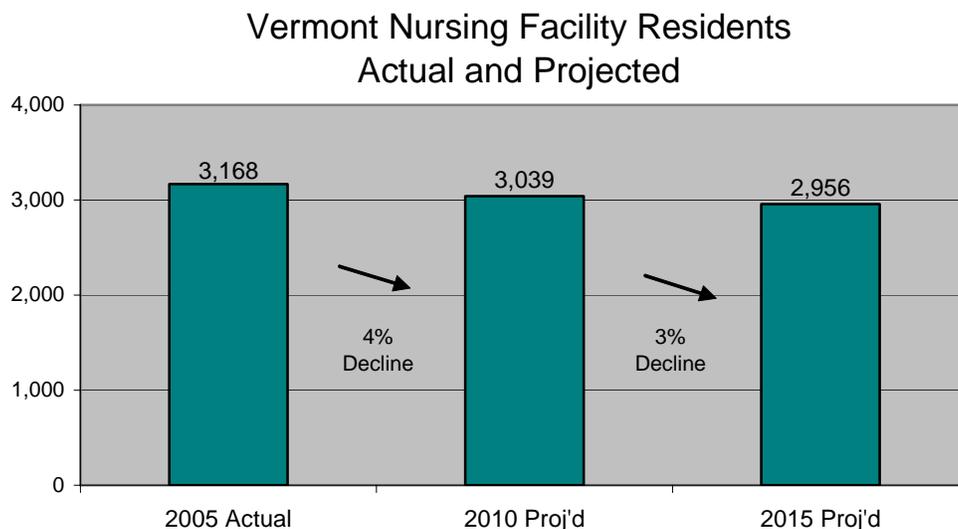
A recent change in state law is adding pressure to nursing facilities with low occupancy. Until this year, if a nursing facility had 90% occupancy, its costs were treated as if it were at full occupancy. That threshold has been raised to 93% in order to promote a more efficient system and avoid paying unnecessarily for empty beds. This means if a facility's occupancy is below 93% when "re-basing" occurs (a process of rate adjustments to reflect current costs), the daily rate would be lower than it would have been previously. As a result of this change, some facilities are contemplating a reduction in capacity to eliminate empty beds and thereby maintain higher occupancy levels. Two facilities have recently de-licensed a total of 18 empty beds.

Vermont is constantly challenged to ensure that the State maintains an adequate number of beds and that quality remains high. Over the years, some nursing facilities have received "extraordinary financial relief" to secure their viability. In one case, the facility was the only remaining nursing home in the county. The State needs to support such facilities even as occupancy declines and downsizing occurs.

Unfortunately, the turnover among nursing facility administrators and directors of nursing is very high. This high turnover of management could lead to a decline in the quality of care. However, some facilities are adopting new practices to improve resident care as well as the working environment. One of those facilities has successfully launched a special unit for ventilator patients. Seventeen nursing facilities participated in Vermont's "Gold Star" program to enhance the recruitment and retention of staff in 2005.

Overall, the quality of care in Vermont nursing homes remains high and many facilities have healthy occupancy and a strong financial base. However, the industry will continue to be a system under stress as it adjusts to the new reality of Vermont's increasingly available home and community-based alternatives.

The Department's model predicts the number of nursing facility residents in 2010 and 2015 based on historical use patterns and demographic changes. Vermont's projected decline of 212 residents over the 10-year period is displayed below. (See Appendix, Table 5, p.32-1 to 32-3 for county detail.)



Area Agencies on Aging

Vermont's five Area Agencies on Aging (AAA's) play a key role in planning and developing comprehensive and coordinated systems to enhance the ability of older Vermonters to:

- live as independently as possible, and
- be active and contributing members of the community.

The work of the AAA's is far reaching with a focus on improving the lives of older Vermonters and family caregivers with regard to income, housing, nutrition, health, employment, retirement, and social and community services.

In Federal Fiscal Year 2005, Vermont AAA's provided or supported services to well over 46,000 older Vermonters and family caregivers. Long considered the gateway to services and resources, the AAA's toll-free Senior HelpLine provides comprehensive and objective information, referral services and assistance. Through the Senior HelpLine and other means, AAA's responded to almost 32,000 requests for information and assistance from older Vermonters, family caregivers and other community members. Case Management is the other core service provided by the AAA's in helping older Vermonters and family caregivers maintain their independence. AAA's certified case managers provided services to over 8,500 individuals in Federal Fiscal Year 2005.

Area Agencies on Aging are primarily planning and development agencies. With the exception of Information, Referral & Assistance and Case Management, AAA's do not directly provide services but instead contract with other local community agencies who provide personal care, chore, homemaker, legal and transportation services. Ensuring that older Vermonters have access to transportation is a particular challenge for a rural state such as Vermont which has limited transportation resources. Over the past year, the AAA's provided support for almost 88,000 trips so that older Vermonters could receive essential medical care and other community services. AAA's also furnish essential support for nutrition programs including home-delivered and community meals, nutrition counseling and education, as well as a range of disease prevention and health promotion activities offered at over one hundred senior centers and other local organizations. In 2005, AAA's supported the provision of over 631,000 home delivered meals and nearly 384,500 community meals throughout Vermont.

The AAA's also play a key role in addressing broad systems issues that impact older Vermonters and family caregivers. Over the past year, the AAA's were actively involved in shaping the development of Vermont's Choices for Care 1115 Medicaid Waiver Program. With the implementation of the new Medicare Part D pharmacy benefit, the AAA's successfully supported efforts to hold harmless participants in Vermont's state pharmacy programs as well as provide public education and

individual assistance to beneficiaries. The AAA's are already bracing for the aging of Vermont's population, knowing their role will become increasingly important. Without the locally based Area Agencies on Aging, Vermont would be unprepared to meet the needs of its older population and support the growing number of family caregivers.

Best Practice Targets

This year's report includes a new section on "best practice" targets for Vermont's long term care system. Each county's network of long term care services is distinctive, addressing the unique needs of its community. Best practice targets show counties the level of program utilization they might experience if their programs were to mirror a "best practice" standard. A county's actual utilization can be compared with best practice targets thereby highlighting strengths as well as areas for enhancement. With the implementation of Vermont's new Choices for Care program, counties have a rare opportunity to strike a more equal balance between institutional and home-based services.

The "Best Practice Targets" table (see page 24) portrays each county's 2005 actual use of a given service and contrasts it with best practice use. Targets focus on four services: Nursing Facility, Medicaid Waiver Personal Care, Adult Day and Enhanced Residential Care. Actual program use and best practice targets are for FY 2005, which is prior to implementation of Vermont's new Choices for Care program. The Choices for Care program is expected to further increase counties' ability to serve people in home and community-based settings.

The Department derived "best practice use rates" for each of the four services by blending the *actual* FY 2005 utilization in three high performing counties (Addison, Chittenden and Franklin). These three counties were chosen for the best practice use rates because they had low nursing home utilization combined with high use of home and community-based services. Although Franklin County's nursing home utilization is not among the lowest in the state, the county more than makes up for it with its well-developed home and community-based system. The same three counties were used to produce the best practice use rates for each service.

The best practice use rate for each service was then applied to the number of individuals with a disability (2+ ADLs) age 18 and older in each county to derive the number of people who would have been served in FY 2005 had that county's use rate been the same as the "best practice use rate". For each service, the Best Practice Targets table provides each county's actual 2005 use rate among people with a disability along with the number of people served, followed by the number of people who would have been served had "best practice" utilization patterns been in force. When the actual number served is the same as or exceeds the best practice target, the actual number served becomes the "best practice number to serve" and is marked in bold on the Best Practice Targets table. This approach is employed for all people with disabilities age 18 and older needing long term care, not just those utilizing Medicaid services. Best practice targets are not to be confused with the Department's Medicaid Choices for Care goal of a "60/40 balance" discussed earlier in this report.

The best practice use rate for nursing facilities in FY 2005 was 36.3%. This figure was derived by totaling the number of nursing facility residents in the three high performing counties and dividing by the number of people with disabilities age 18 and older in those three counties. Multiplying the use rate of 36.3% times the number of people with a disability in each county gives the nursing facility “2005 Best Practice Number to Serve” for each county. (Essex and Grand Isle Counties have no nursing facility. Numbers may not total due to rounding.)

The same approach was used for the three home and community-based services whose “best practice” use rates are as follows: Medicaid Waiver Personal Care — 26.2%, Adult Day — 24.8%, and Enhanced Residential Care (ERC) — 5.5%. (Essex and Grand Isle Counties had no ERC providers in FY 2005.)

Comparing among the four services, one can see that there are three or four counties in each service that meet or exceed the best practice target (see bold numbers). These three or four counties vary from one service to the next, which speaks to the differing strengths in each county.

- Orleans, Rutland, Washington and Windsor Counties show strength in Enhanced Residential Care but need to augment other parts of their home and community-based long term care system.
- Chittenden County may need to focus on development of more ERC and Adult Day services.
- Orange County may want to expand its Adult Day participation.
- Caledonia and Lamoille Counties could consider increasing their use of ERC providers.
- Windham County has one of the lowest nursing facility use rates in the state but also has significantly lower than average use of all three home and community-based programs listed. This suggests that Windham County may need to strengthen its home and community-based programs across the board.
- Bennington County is the only county that appears to need improvement in all four services.
- Conversely, Addison County is the only county that meets or exceeds the best practice targets in all four services.

Those long term care services not included in the Best Practice Targets table round out the blend of options in each county. Particularly noteworthy is assisted living in which four counties have taken the lead—Chittenden, Rutland, Windham and Windsor. Programs such as these provide valuable models for the future of Vermont’s long term care system.

Best Practice Targets

Nursing Facility–2005	Vermont	Addison	Benn	Caledonia	Chitt	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Wash	Windham	Windsor
Actual Use Rate in 2005	42%	29%	62%	41%	36%		42%		44%	8%	52%	43%	50%	36%	39%
Actual # Served in 2005	3,168	98	493	163	519		202		123	20	246	392	411	203	299
2005 Best Practice # to Serve*	2,618	98	288	143	519		176		101	20	170	330	295	203	276

MW Personal Care–2005	Vermont	Addison	Benn	Caledonia	Chitt	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Wash	Windham	Windsor
Actual Use Rate in 2005	22%	31%	13%	26%	23%	21%	33%	33%	24%	24%	18%	19%	18%	16%	24%
Actual # Served in 2005	970	76	40	60	207	11	95	16	38	52	41	96	72	59	112
2005 Best Practice # to Serve*	1,190	76	79	60	239	13	95	16	41	55	59	135	106	96	121

Adult Day–2005	Vermont	Addison	Benn	Caledonia	Chitt	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Wash	Windham	Windsor
Actual Use Rate in 2005	19%	76%	16%	42%	12%	16%	21%	24%	28%	15%	15%	8%	15%	16%	10%
Actual # Served in 2005	836	184	49	96	113	8	60	11	43	31	34	42	62	57	46
2005 Best Practice # to Serve*	1,260	184	75	96	227	13	70	12	43	52	55	128	100	91	114

ERC–2005	Vermont	Addison	Benn	Caledonia	Chitt	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Wash	Windham	Windsor
Actual Use Rate in 2005	4%	6%	1%	0.4%	4%		11%		0.6%	5%	4%	5%	5%	2%	5%
Actual # Served in 2005	182	15	3	1	34		30		1	10	10	26	22	9	21
2005 Best Practice # to Serve*	258	15	17	13	50	3	30	3	9	12	12	28	22	20	25

* When the actual number served is the same as or exceeds the best practice target, the actual number served becomes the “best practice number to serve” (shown in bold). Numbers do not total due to rounding.

APPENDIX

ASSUMPTIONS SHEET

Annual % change in per capita disability rate by age group.

Disability Rate Trends (non-MR/DD)

	2000-2005	2005-2010	2010-2015
0-64*	3.7%	3.0%	2.6%
65+**	-0.9%	-0.9%	-0.8%

Default values:

	'00-05	'05-'10	'10-'15
0-64	3.7%	3.0%	2.6%
65+	-0.9%	-0.9%	-0.8%

*Default disability trends for 0-64 population assumes same rate of increase as assumed by the Social Security administration for Disabled Workers (i.e., individuals receiving Social Security Disability Insurance benefits) from the 2005 Annual Trustees Report. Lewin applied these trends to all individuals younger than age 65, as little good projection data exist for individuals younger than 18.

**Default disability trends for the 65+ population are informed by disability trends reported by Manton from the National Long Term Care Survey. From Manton's age-adjusted trend analysis, Lewin derived that the percentage of individuals having difficulty with 1+ ADL (2+ ADLs were not reported separately) decreased by 1% annually from 1989 to 1999. We assume a slight flattening of this trend in the future.

Nursing Facility Use Rate Trends***

Annual % change in per capita nursing facility use rate by age group.

	2005-2010	2010-2015
0-64	-0.2%	-0.2%
65-74	-2.4%	-2.4%
75-84	-1.8%	-1.8%
85+	-3.5%	-3.5%

Note: VT historical trends:

	'92-'05	'92-'00	'00-'05
0-64	-0.2%	-0.7%	0.4%
65-74	-2.4%	-2.4%	-2.5%
75-84	-2.1%	-1.8%	-2.4%
85+	-3.8%	-3.5%	-4.4%

Default values:

	'05-'10	'10-'15
0-64	-0.2%	-0.2%
65-74	-2.4%	-2.4%
75-84	-1.8%	-1.8%
85+	-3.5%	-3.5%

***Includes all payers, i.e., both public and private pay nursing facility residents. Default trend assumptions are based on the observed trends in nursing facility use rates through the second calendar quarter of 2005. Lewin conservatively assumed that the age-specific changes in nursing facility use from 2005 to 2015 will resemble the minimum change observed over the long term (1992-2005) and changes observed during two sub-periods that comprise this period (1992-2000 and 2000-2005).

Table 2

**Estimated Number of People with LTC Needs¹ by County, 2005, 2010 proj, and 2015 proj.
By Disability Level and Income, Persons of All Ages
Point in Time**

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
2005															
Nursing Facility ^{2,3}	3,168	98	493	163	519	-	202	-	123	20	246	392	411	203	299
Community ⁴	621,068	36,939	36,788	30,044	152,025	6,603	47,160	7,423	24,319	28,927	26,354	63,383	58,524	44,890	57,689
All <175% FPL	132,490	7,430	8,125	7,106	31,141	1,678	9,856	1,486	5,202	6,162	6,661	14,462	11,804	9,622	11,755
2+ ADLs	1,830	98	122	98	387	23	121	19	66	87	100	217	162	149	182
1+ ADLs	3,281	176	221	178	693	43	219	34	119	155	176	387	291	259	330
Any ADL or IADL	6,856	369	471	375	1,416	92	460	75	249	325	364	808	609	536	709
All 175%+ FPL	488,578	29,510	28,663	22,938	120,884	4,925	37,304	5,937	19,117	22,765	19,693	48,921	46,720	35,268	45,934
2+ ADLs	2,658	148	185	137	545	28	170	29	93	128	128	309	249	223	286
1+ ADLs	4,932	278	340	252	1,031	54	323	56	177	236	230	561	465	399	529
Any ADL or IADL	10,809	611	744	550	2,280	120	718	128	394	515	495	1,215	1,024	855	1,162
2010 Projected															
Nursing Facility ^{2,3}	3,039	95	465	158	516	-	199	-	120	30	235	367	380	191	284
Community ⁴	634,437	37,794	36,942	30,707	156,648	6,711	49,114	7,923	25,481	29,481	26,910	63,726	59,321	45,578	58,101
All <175% FPL	135,318	7,607	8,148	7,237	32,141	1,707	10,260	1,593	5,449	6,267	6,788	14,528	11,957	9,764	11,873
2+ ADLs	2,139	114	145	114	454	27	143	23	79	99	117	249	189	172	213
1+ ADLs	3,722	200	251	200	794	48	252	42	139	174	200	430	327	292	373
Any ADL or IADL	7,640	413	520	412	1,602	102	521	91	286	361	404	881	668	595	785
All 175%+ FPL	499,119	30,187	28,794	23,469	124,507	5,005	38,855	6,330	20,032	23,214	20,122	49,198	47,364	35,814	46,228
2+ ADLs	3,085	170	219	157	639	33	200	36	112	146	150	352	288	255	329
1+ ADLs	5,555	311	385	279	1,174	61	369	68	206	263	261	621	519	446	591
Any ADL or IADL	11,978	678	817	597	2,560	133	808	154	452	570	549	1,319	1,121	946	1,273
2015 Projected															
Nursing Facility ^{2,3}	2,956	95	450	153	520	-	196	-	120	30	229	348	364	184	269
Community ⁴	647,419	38,690	37,067	31,410	160,662	6,848	51,226	8,433	26,637	30,052	27,472	64,131	59,991	46,272	58,529
All <175% FPL	138,868	7,848	8,217	7,441	33,148	1,751	10,750	1,713	5,726	6,432	6,950	14,685	12,167	9,980	12,060
2+ ADLs	2,504	134	172	133	539	30	171	28	95	115	135	286	221	199	247
1+ ADLs	4,289	232	289	229	931	54	296	51	165	199	227	484	375	335	423
Any ADL or IADL	8,718	476	584	466	1,866	113	603	110	338	412	454	979	760	678	878
All 175%+ FPL	508,550	30,842	28,850	23,969	127,514	5,097	40,475	6,719	20,911	23,621	20,522	49,446	47,824	36,291	46,469
2+ ADLs	3,578	197	255	180	752	37	235	44	135	167	173	399	335	293	376
1+ ADLs	6,372	359	437	317	1,370	68	429	83	245	300	297	695	597	510	666
Any ADL or IADL	13,695	783	914	675	2,982	148	935	186	536	652	619	1,470	1,283	1,083	1,429

¹LTC needs are defined as requiring the help of another person to perform ADLs and/or IADLs. Excludes individuals with mental retardation or developmental disabilities.

²Represents average daily number of nursing facility residents in fiscal year, based on quarterly MDS data (includes Wake Robin but excludes Arbors and Mertens). Nursing facility residents not broken out by income or disability level because data are unavailable.

³Nursing facility "need" assumes that all individuals in nursing facilities in 2005 "needed" nursing facility care. Trend in nursing facility need over time is based on use trend assumption entered on ASSUMPTIONS sheet. All individuals in nursing homes are assumed to have 2+ ADLs.

⁴Community residents include individuals residing in non-institutional settings. This includes people living in their homes, as well as people living in residential care and congregate housing with supportive services.

Sources and Notes:

Estimates and projections of LTC need are modeled using data from the following sources: Vermont-specific data on broad disability and population characteristics from the 2000 Census Public Use Microdata Sample (PUMS); national-level information on specific activity limitations from the 1996 panel of the Survey of Income and Program Participation (SIPP); Vermont-specific information income data from the 1999-2001 Current Population Survey, March Supplement; county-level data on income and population characteristics from the 2000 Census; and assumptions about disability and institutionalization trends entered on ASSUMPTIONS sheet of this workbook.

Table 3

**Estimated Number of People with LTC Needs¹ by County, 2005, 2010 proj, and 2015 proj.
Individuals Needing Assistance with 2+ ADLs
By Age Group and Income
Point in Time**

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
2005															
Nursing Facility ^{2,3}	3,168	98	493	163	519	-	202	-	123	20	246	392	411	203	299
Community, Low Income (<175%FPL) ⁴	1,830	98	122	98	387	23	121	19	66	87	100	217	162	149	182
<65	672	37	39	34	170	8	48	7	27	30	33	73	60	48	57
<18	34	2	2	2	7	1	3	0	1	2	2	4	3	3	2
18-64	637	36	37	32	164	8	45	7	26	28	31	69	57	45	54
65+	1,158	61	83	63	216	15	73	11	39	57	67	144	102	101	125
65-74	289	15	20	15	52	5	21	4	12	15	16	33	26	24	32
75-84	320	17	24	21	57	5	23	4	10	16	17	39	25	27	36
85+	549	29	39	28	107	6	30	4	17	25	35	71	51	50	58
Community, 175%+ FPL ⁴	2,658	148	185	137	545	28	170	29	93	128	128	309	249	223	286
<65	690	42	39	32	178	7	52	8	27	32	27	68	67	49	63
<18	48	3	3	2	12	0	4	1	2	2	2	5	5	3	4
18-64	642	39	36	29	166	6	48	8	25	30	25	63	62	46	58
65+	1,968	106	146	105	368	22	118	20	66	97	101	241	182	173	223
65-74	436	23	32	21	79	6	28	7	18	23	21	50	43	37	51
75-84	831	46	64	50	151	10	54	9	27	42	38	101	72	71	97
85+	701	37	50	34	138	6	37	5	21	32	42	90	68	65	75

¹LTC Needs defined as requiring the help of another person to perform two or more Activities of Daily Living (ADLs), excluding individuals with mental retardation/developmental disabilities.

²Represents average daily number of nursing facility residents in fiscal year, based on quarterly MDS data (includes Wake Robin but excludes Arbors and Mertens). Nursing facility residents not broken out by income or disability level because data are unavailable.

³Nursing facility "need" assumes that all individuals in nursing facilities in 2005 "needed" nursing facility care. Trend in nursing facility need over time is based on use trend assumption entered on ASSUMPTIONS sheet. All individuals in nursing homes are assumed to have 2+ ADLs.

⁴Community residents include individuals residing in non-institutional settings. This includes people living in their homes, as well as people living in residential care and congregate housing with supportive services.

Sources and Notes:

Estimates and projections of LTC need are modeled using data from the following sources: Vermont-specific data on broad disability and population characteristics from the 2000 Census Public Use Microdata Sample (PUMS); national-level information on specific activity limitations from the 1996 panel of the Survey of Income and Program Participation (SIPP); Vermont-specific information income data from the 1999-2001 Current Population Survey, March Supplement; county-level data on income and population characteristics from the 2000 Census; and assumptions about disability and institutionalization trends entered on ASSUMPTIONS sheet of this workbook.

Table 3

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Individuals Needing Assistance with 2+ ADLs
By Age Group and Income
Point in Time**

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
2010 Projected															
Nursing Facility ^{2,3}	3,039	95	465	158	516	-	199	-	120	30	235	367	380	191	284
Community, Low Income (<175%FPL) ⁴	2,139	114	145	114	454	27	143	23	79	99	117	249	189	172	213
<65	716	40	41	37	184	9	52	8	29	32	35	77	64	50	60
<18	33	2	2	2	7	1	3	0	1	2	2	4	3	2	2
18-64	683	38	39	35	177	8	49	8	28	30	33	73	61	48	57
65+	1,423	75	104	77	270	18	91	15	50	67	82	173	125	121	154
65-74	362	20	25	18	66	6	26	6	15	18	20	41	32	30	39
75-84	346	18	27	20	63	5	25	4	12	18	18	41	28	29	38
85+	715	37	52	38	141	7	41	5	22	31	44	90	65	63	77
Community, 175%+ FPL ⁴	3,085	170	219	157	639	33	200	36	112	146	150	352	288	255	329
<65	735	45	41	34	191	7	57	9	30	34	28	71	70	52	66
<18	47	3	3	2	12	0	4	1	2	2	2	5	4	3	4
18-64	688	42	38	32	180	7	52	9	28	32	26	67	66	49	61
65+	2,351	125	178	123	448	26	143	27	82	112	122	281	218	203	264
65-74	544	30	39	26	100	7	35	9	23	27	27	61	52	47	62
75-84	897	48	71	50	166	11	59	11	31	46	42	106	79	76	101
85+	910	47	68	47	181	8	50	7	28	39	53	114	87	81	100

¹LTC Needs defined as requiring the help of another person to perform two or more Activities of Daily Living (ADLs), excluding individuals with mental retardation/developmental disabilities.

²Represents average daily number of nursing facility residents in fiscal year, based on quarterly MDS data (includes Wake Robin but excludes Arbors and Mertens). Nursing facility residents not broken out by income or disability level because data are unavailable.

³Nursing facility "need" assumes that all individuals in nursing facilities in 2005 "needed" nursing facility care. Trend in nursing facility need over time is based on use trend assumption entered on ASSUMPTIONS sheet. All individuals in nursing homes are assumed to have 2+ ADLs.

⁴Community residents include individuals residing in non-institutional settings. This includes people living in their homes, as well as people living in residential care and congregate housing with supportive services.

Sources and Notes:

Estimates and projections of LTC need are modeled using data from the following sources: Vermont-specific data on broad disability and population characteristics from the 2000 Census Public Use Microdata Sample (PUMS); national-level information on specific activity limitations from the 1996 panel of the Survey of Income and Program Participation (SIPP); Vermont-specific information income data from the 1999-2001 Current Population Survey, March Supplement; county-level data on income and population characteristics from the 2000 Census; and assumptions about disability and institutionalization trends entered on ASSUMPTIONS sheet of this workbook.

Table 3

**Estimated Number of People with LTC Needs¹ by County, 2005, 2010 proj, and 2015 proj.
Individuals Needing Assistance with 2+ ADLs
By Age Group and Income
Point in Time**

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
2015 Projected															
Nursing Facility ^{2,3}	2,956	95	450	153	520	-	196	-	120	30	229	348	364	184	269
Community, Low Income (<175%FPL) ⁴	2,504	134	172	133	539	30	171	28	95	115	135	286	221	199	247
<65	807	45	45	41	210	10	61	9	34	36	39	85	71	56	66
<18	37	2	2	3	7	1	3	0	2	2	3	4	3	3	2
18-64	770	43	43	39	203	9	58	9	32	34	37	80	68	53	63
65+	1,697	89	127	92	329	21	110	19	61	79	96	201	150	143	181
65-74	476	27	32	25	89	7	34	7	20	24	25	53	42	40	50
75-84	377	19	28	21	70	5	26	5	15	19	20	44	32	31	41
85+	845	43	66	46	170	9	50	6	27	36	50	104	76	72	90
Community, 175%+ FPL ⁴	3,578	197	255	180	752	37	235	44	135	167	173	399	335	293	376
<65	828	50	45	38	219	8	66	11	34	38	32	79	78	57	72
<18	52	3	3	3	13	1	5	1	2	2	2	5	5	3	4
18-64	776	47	42	36	206	7	61	10	32	36	30	74	73	54	68
65+	2,750	147	210	141	534	29	168	33	100	128	141	321	257	236	304
65-74	708	41	50	35	135	8	46	11	29	35	33	77	69	61	79
75-84	971	51	75	50	182	11	62	14	37	49	47	112	89	82	109
85+	1,071	55	85	56	217	10	60	8	34	45	61	132	99	92	116

¹LTC Needs defined as requiring the help of another person to perform two or more Activities of Daily Living (ADLs), excluding individuals with mental retardation/developmental disabilities.

²Represents average daily number of nursing facility residents in fiscal year, based on quarterly MDS data (includes Wake Robin but excludes Arbors and Mertens). Nursing facility residents not broken out by income or disability level because data are unavailable.

³Nursing facility "need" assumes that all individuals in nursing facilities in 2005 "needed" nursing facility care. Trend in nursing facility need over time is based on use trend assumption entered on ASSUMPTIONS sheet. All individuals in nursing homes are assumed to have 2+ ADLs.

⁴Community residents include individuals residing in non-institutional settings. This includes people living in their homes, as well as people living in residential care and congregate housing with supportive services.

Sources and Notes:

Estimates and projections of LTC need are modeled using data from the following sources: Vermont-specific data on broad disability and population characteristics from the 2000 Census Public Use Microdata Sample (PUMS); national-level information on specific activity limitations from the 1996 panel of the Survey of Income and Program Participation (SIPP); Vermont-specific information income data from the 1999-2001 Current Population Survey, March Supplement; county-level data on income and population characteristics from the 2000 Census; and assumptions about disability and institutionalization trends entered on ASSUMPTIONS sheet of this workbook.

Table 3a

Percent Distribution of Community Residents with LTC Needs¹ by County, 2005, 2010 proj, and 2015 proj.

Individuals Needing Assistance with 2+ ADLs, by Age Group

Persons of All Income Levels

Point in Time



	Vermont (100%)	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
Age <18															
2005	82	5.8%	6.0%	5.7%	22.4%	1.3%	8.7%	1.1%	3.9%	4.8%	5.4%	10.7%	9.0%	7.0%	8.1%
2010 proj.	80	5.9%	5.8%	5.7%	22.6%	1.3%	9.0%	1.2%	4.0%	4.7%	5.5%	10.6%	9.0%	6.9%	7.9%
2015 proj.	89	5.9%	5.7%	5.9%	22.5%	1.3%	9.2%	1.2%	4.1%	4.7%	5.5%	10.6%	8.9%	6.9%	7.7%
Age 18-64															
2005	1,279	5.8%	5.7%	4.8%	25.8%	1.1%	7.2%	1.1%	4.0%	4.5%	4.3%	10.4%	9.3%	7.2%	8.8%
2010 proj.	1,371	5.8%	5.6%	4.8%	26.0%	1.1%	7.4%	1.2%	4.1%	4.5%	4.3%	10.2%	9.3%	7.1%	8.7%
2015 proj.	1,547	5.8%	5.5%	4.8%	26.4%	1.1%	7.7%	1.2%	4.2%	4.5%	4.3%	10.0%	9.1%	6.9%	8.5%
Age 18+															
2005	4,406	5.5%	6.8%	5.2%	20.7%	1.2%	6.4%	1.1%	3.5%	4.8%	5.1%	11.7%	9.2%	8.3%	10.5%
2010 proj.	5,144	5.4%	7.0%	5.2%	20.9%	1.1%	6.5%	1.1%	3.6%	4.7%	5.1%	11.5%	9.1%	8.2%	10.4%
2015 proj.	5,994	5.4%	7.0%	5.1%	21.2%	1.1%	6.6%	1.2%	3.8%	4.6%	5.1%	11.3%	9.1%	8.1%	10.3%
Age 65+															
2005	3,126	5.3%	7.3%	5.4%	18.7%	1.2%	6.1%	1.0%	3.3%	4.9%	5.4%	12.3%	9.1%	8.8%	11.1%
2010 proj.	3,774	5.3%	7.5%	5.3%	19.0%	1.2%	6.2%	1.1%	3.5%	4.7%	5.4%	12.0%	9.1%	8.6%	11.1%
2015 proj.	4,447	5.3%	7.6%	5.2%	19.4%	1.1%	6.3%	1.2%	3.6%	4.7%	5.3%	11.7%	9.1%	8.5%	10.9%

¹LTC Needs defined as requiring the help of another person to perform two or more Activities of Daily Living (ADLs), excluding individuals with mental retardation/developmental disabilities. Community residents include individuals residing in non-institutional settings. This includes people living in their homes, as well as people living in residential care and congregate housing with supportive services.

Sources and Notes:

Estimates and projections of LTC need are modeled using data from the following sources: Vermont-specific data on broad disability and population characteristics from the 2000 Census Public Use Microdata Sample (PUMS); national-level information on specific activity limitations from the 1996 panel of the Survey of Income and Program Participation (SIPP); Vermont-specific information income data from the 1999-2001 Current Population Survey, March Supplement; county-level data on income and population characteristics from the 2000 Census; and assumptions about disability and institutionalization trends entered on ASSUMPTIONS sheet of this workbook.

Table 3b

**Distribution of Community Residents with LTC Needs¹ by County, 2005, 2010 proj, and 2015 proj.
Individuals Needing Assistance with 2+ ADLs, by Age Group
Persons of All Income Levels
Point in Time**

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
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Age <18																
2005	82	5	5	5	18	1	7	1	3	4	4	9	7	6	7	
2010 proj.	80	5	5	5	18	1	7	1	3	4	4	8	7	6	6	
2015 proj.	89	5	5	5	20	1	8	1	4	4	5	9	8	6	7	
Age 18-64																
2005	1,279	75	73	61	330	14	92	15	51	58	55	133	119	91	113	
2010 proj.	1,371	80	77	66	357	15	102	16	56	62	59	139	127	97	119	
2015 proj.	1,547	90	85	74	409	16	119	19	65	70	67	154	141	107	131	
Age 18+																
2005	4,406	242	301	230	914	51	284	46	155	212	223	517	404	366	461	
2010 proj.	5,144	280	359	266	1,075	59	336	58	188	241	263	593	470	421	536	
2015 proj.	5,994	326	422	308	1,271	66	397	71	226	277	303	675	548	486	616	
Age 65+																
2005	3,126	167	228	169	584	37	192	32	104	154	168	384	284	274	348	
2010 proj.	3,774	200	283	200	718	44	235	42	132	179	203	454	343	325	418	
2015 proj.	4,447	236	337	233	862	50	278	52	162	207	237	521	407	379	485	

¹LTC Needs defined as requiring the help of another person to perform two or more Activities of Daily Living (ADLs), excluding individuals with mental retardation/developmental disabilities. Community residents include individuals residing in non-institutional settings. This includes people living in their homes, as well as people living in residential care and congregate housing with supportive services.

Sources and Notes:

Estimates and projections of LTC need are modeled using data from the following sources: Vermont-specific data on broad disability and population characteristics from the 2000 Census Public Use Microdata Sample (PUMS); national-level information on specific activity limitations from the 1996 panel of the Survey of Income and Program Participation (SIPP); Vermont-specific information income data from the 1999-2001 Current Population Survey, March Supplement; county-level data on income and population characteristics from the 2000 Census; and assumptions about disability and institutionalization trends entered on ASSUMPTIONS sheet of this workbook.

Table 4
Actual and Projected Users of Long Term Care Services in Vermont by Program, 2005, 2010,
and 2015¹
Selected Programs/Services, Point in Time

	FY 2005 Actual	FY 2010 Proj.	FY 2015 Proj.	Growth Rates	
				2005-2010	2010-2015
Nursing Facilities (All payers) ²	3,168	3,039	2,956	-4%	-3%
Enhanced Residential Care--Medicaid Waiver	182	247	311	36%	26%
Residential Care--ACCS (Medicaid State Plan)	713	900	1,101	26%	22%
Residential Care -- Private Pay	1,000	1,268	1,560	27%	23%
Assisted Living	250	342	425	37%	24%
Congregate Housing with Supportive Services (HASS)	910	1,135	1,386	25%	22%
Medicaid Waiver Personal Care	970	1,220	1,497	26%	23%
Medicaid Waiver Respite	631	793	971	26%	22%
Medicaid Waiver Traumatic Brain Injury	48	49	49	3%	-1%
Medicaid Waiver Case Management	1,136	1,447	1,781	27%	23%
Attendant Services Program (ASP)	286	326	381	14%	17%
Adult day	836	1,051	1,287	26%	22%
Homemaker Services	648	814	998	26%	23%
VCIL Home Delivered Meals (disabled clients)	258	276	312	7%	13%
Mental Health and Aging	486	606	747	25%	23%

¹Individuals may use more than one service. Residents of nursing facilities and Residential Care-Private Pay represent an average daily census. The FY 2005 number of nursing facility residents was derived by averaging quarterly MDS resident counts. The FY 2005 number of Residential Care-Private Pay users was derived from a point-in-time census count done during FY 2005. User counts for all other services represent the average number of individuals with use during a month. The FY 2005 Medicaid program data are derived from EDS paid claims on date of service; other FY 2005 program data are derived from reported program use. Age and county distributions for Adult Day and Homemaker were extrapolated from SAMS data and applied to provider service report totals. Medicaid Waiver Respite includes Companion Services; previous reports did not include Companion. Counts represent the user's current county of residence. Projections of use assume current use patterns by age, and nursing home and disability trends entered on ASSUMPTIONS sheet. Changes over time therefore are the result of demographic trends and the assumed trends in institutionalization and disability, but assume no other changes in LTC policy.

²Nursing facility residents include Wake Robin but exclude Arbors and Mertens.

Table 5
Actual and Projected Use¹ of Long Term Care Services in Vermont by Program by County, 2005, 2010, and 2015
Selected Programs/Services
Point in Time

	Vermont ²	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor	
FY 2005 Actual																
Number of Users																
Nursing Facilities (All payers) ³	3,168	98	493	163	519	0	202	0	123	20	246	392	411	203	299	
Enhanced Residential Care--Medicaid Waiver	182	15	3	1	34	0	30	0	1	10	10	26	22	9	21	
Residential Care--ACCS (Medicaid State Plan)	713	24	34	28	82	16	76	2	25	28	56	128	127	22	65	
Residential Care -- Private Pay	1,000	26	188	31	288	9	34	0	58	36	37	60	154	64	15	
Assisted Living	250	0	0	0	26	0	0	0	0	0	0	65	0	42	117	
Congregate Housing with Supportive Services (HASS)	910	50	61	21	186	27	23	1	126	32	12	242	84	35	11	
Medicaid Waiver Personal Care	970	76	40	60	207	11	95	16	38	52	41	96	72	59	112	
Medicaid Waiver Respite	631	63	20	42	126	9	63	10	16	36	35	68	42	36	65	
Medicaid Waiver Traumatic Brain Injury	48	3	1	2	2	0	6	0	7	1	2	7	13	1	3	
Medicaid Waiver Case Management	1,136	90	45	57	252	10	124	17	35	57	40	113	93	68	135	
Attendant Services Program (ASP)	286	10	13	11	47	1	22	7	13	13	9	64	30	24	22	
Adult Day	836	184	49	96	113	8	60	11	43	31	34	42	62	57	46	
Homemaker Services	648	47	45	32	42	12	20	1	35	41	64	81	111	61	56	
VCIL Home Delivered Meals (disabled clients)	258	13	22	18	57	6	16	4	8	10	3	35	32	12	22	
Mental Health and Aging ⁴	486	57	26	63	53	0	54	0	0	0	0	67	100	66	0	

¹Individuals may use more than one service. Residents of nursing facilities and Residential Care-Private Pay represent an average daily census. The FY 2005 number of nursing facility residents was derived by averaging quarterly MDS resident counts. The FY 2005 number of Residential Care-Private Pay users was derived from a point-in-time census count done during FY 2005. User counts for all other services represent the average number of individuals with use during a month. The FY 2005 Medicaid program data are derived from EDS paid claims on date of service; other FY 2005 program data are derived from reported program use. Age and county distributions for Adult Day and Homemaker were extrapolated from SAMS data and applied to provider service report totals. Medicaid Waiver Respite includes Companion Services; previous reports did not include Companion. Counts represent the user's current county of residence. Projections of use assume current use patterns by age, and nursing home and disability trends entered on ASSUMPTIONS sheet. Changes over time therefore are the result of demographic trends and the assumed trends in institutionalization and disability, but assume no other changes in LTC policy.

²County estimates may not sum to state total because the State provides some services to Vermont residents with mailing addresses outside of Vermont.

³Nursing facility counts include Wake Robin but exclude Arbors and Mertens.

⁴Some counties report Mental Health & Aging clients in groups of counties: Caledonia/Essex/Orleans are listed under Caledonia; Franklin/Grand Isle are listed under Franklin; Washington/Orange/Lamoille are listed under Washington; and Windham/Windsor are listed under Windham.

Table 5

**Actual and Projected Use¹ of Long Term Care Services in Vermont by Program by County, 2005, 2010, and 2015
Selected Programs/Services
Point in Time**

	Vermont ²	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
FY 2010 Projected															
Number of Users															
Nursing Facilities (All payers) ³	3,039	95	465	158	516	0	199	0	120	30	235	367	380	191	284
Enhanced Residential Care--Medicaid Waiver	247	20	5	1	47	0	42	0	1	13	13	35	31	13	27
Residential Care--ACCS (Medicaid State Plan)	900	31	43	34	107	18	103	3	30	33	69	162	159	28	81
Residential Care -- Private Pay	1,268	34	237	38	377	10	46	0	70	43	46	76	192	82	19
Assisted Living	342	0	0	0	36	0	0	0	0	0	0	86	0	57	163
Congregate Housing with Supportive Services (HASS)	1,135	62	84	27	235	33	28	2	156	38	15	289	108	45	13
Medicaid Waiver Personal Care	1,220	95	53	74	259	13	121	20	49	62	52	118	90	72	143
Medicaid Waiver Respite	793	80	27	52	155	11	80	13	20	44	45	84	53	44	84
Medicaid Waiver Traumatic Brain Injury	49	3	1	2	2	0	6	0	7	1	2	7	13	1	3
Medicaid Waiver Case Management	1,447	115	60	70	319	12	161	22	46	70	51	143	119	86	173
Attendant Services Program (ASP)	326	11	15	12	53	1	25	8	16	14	10	74	35	27	25
Adult Day	1,051	218	64	119	146	10	76	15	58	38	43	50	78	73	60
Homemaker Services	814	59	58	39	56	14	26	1	47	50	83	99	138	74	70
VCIL Home Delivered Meals (disabled clients)	276	14	23	19	62	6	18	4	9	11	3	37	34	13	23
Mental Health and Aging ⁴	606	70	33	76	67	0	70	0	0	0	0	80	127	82	0

32-2

¹Individuals may use more than one service. Residents of nursing facilities and Residential Care-Private Pay represent an average daily census. The FY 2005 number of nursing facility residents was derived by averaging quarterly MDS resident counts. The FY 2005 number of Residential Care-Private Pay users was derived from a point-in-time census count done during FY 2005. User counts for all other services represent the average number of individuals with use during a month. The FY 2005 Medicaid program data are derived from EDS paid claims on date of service; other FY 2005 program data are derived from reported program use. Age and county distributions for Adult Day and Homemaker were extrapolated from SAMS data and applied to provider service report totals. Medicaid Waiver Respite includes Companion Services; previous reports did not include Companion. Counts represent the user's current county of residence. Projections of use assume current use patterns by age, and nursing home and disability trends entered on ASSUMPTIONS sheet. Changes over time therefore are the result of demographic trends and the assumed trends in institutionalization and disability, but assume no other changes in LTC policy.

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³Nursing facility counts include Wake Robin but exclude Arbors and Mertens.

⁴Some counties report Mental Health & Aging clients in groups of counties: Caledonia/Essex/Orleans are listed under Caledonia; Franklin/Grand Isle are listed under Franklin; Washington/Orange/Lamoille are listed under Washington; and Windham/Windsor are listed under Windham.

Table 5
Actual and Projected Use¹ of Long Term Care Services in Vermont by Program by County, 2005, 2010, and 2015
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Point in Time

	Vermont ²	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
FY 2015 Projected															
Number of Users															
Nursing Facilities (All payers) ³	2,956	95	450	153	520	0	196	0	120	30	229	348	364	184	269
Enhanced Residential Care--Medicaid Waiver	311	25	6	1	60	0	54	0	2	16	16	43	38	16	34
Residential Care--ACCS (Medicaid State Plan)	1,101	39	53	41	134	20	129	3	37	40	84	196	194	34	97
Residential Care -- Private Pay	1,560	42	290	46	472	11	58	0	85	51	55	92	235	100	22
Assisted Living	425	0	0	0	46	0	0	0	0	0	0	106	0	71	202
Congregate Housing with Supportive Services (HASS)	1,386	76	107	34	293	38	34	2	192	46	19	340	134	55	16
Medicaid Waiver Personal Care	1,497	118	66	90	320	15	151	24	62	75	64	142	110	87	174
Medicaid Waiver Respite	971	99	34	63	191	13	100	16	26	53	55	100	66	53	103
Medicaid Waiver Traumatic Brain Injury	49	3	1	2	2	0	7	0	7	1	2	7	13	1	3
Medicaid Waiver Case Management	1,781	142	75	85	396	15	200	27	58	85	62	173	148	104	211
Attendant Services Program (ASP)	381	13	17	14	62	1	30	10	19	16	11	87	42	31	28
Adult Day	1,287	257	80	146	183	11	95	20	75	46	53	61	97	89	74
Homemaker Services	998	73	71	47	70	16	33	2	61	61	102	119	170	89	84
VCIL Home Delivered Meals (disabled clients)	312	16	26	22	71	7	21	5	10	12	4	41	38	14	26
Mental Health and Aging ⁴	747	86	41	92	84	0	88	0	0	0	0	95	160	101	0

¹Individuals may use more than one service. Residents of nursing facilities and Residential Care-Private Pay represent an average daily census. The FY 2005 number of nursing facility residents was derived by averaging quarterly MDS resident counts. The FY 2005 number of Residential Care-Private Pay users was derived from a point-in-time census count done during FY 2005. User counts for all other services represent the average number of individuals with use during a month. The FY 2005 Medicaid program data are derived from EDS paid claims on date of service; other FY 2005 program data are derived from reported program use. Age and county distributions for Adult Day and Homemaker were extrapolated from SAMS data and applied to provider service report totals. Medicaid Waiver Respite includes Companion Services; previous reports did not include Companion. Counts represent the user's current county of residence. Projections of use assume current use patterns by age, and nursing home and disability trends entered on ASSUMPTIONS sheet. Changes over time therefore are the result of demographic trends and the assumed trends in institutionalization and disability, but assume no other changes in LTC policy.

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